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UNIVERSITY OF ALBERTA

NURSES AND PATIENTS' PERCEPTIONS OF CONSTANT CARE IN AN ACUTE CARE PSYCHIATRIC FACILITY: A DESCRIPTIVE QUALITATIVE STUDY

by

OLIVE YONGE

A THESIS
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IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

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The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled **NURSES AND PATIENTS' PERCEPTIONS OF CONSTANT CARE IN AN ACUTE CARE PSYCHIATRIC FACILITY: A DESCRIPTIVE QUALITATIVE STUDY** submitted by Olive Yonge in partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

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ABSTRACT

Little is known about constant care (CC) in psychiatric nursing practice. What are the nurses' and patients' perceptions of an intervention that physically binds them together for hours, days and occasionally weeks? Using a descriptive qualitative design, eight patients, eight nurses and four administrative personnel, were interviewed. The interviews were semi-structured, guided by predefined questions and open to other questions and comments as they arose in the interview. The Ethnograph was used to analyze the transcripts. Data on frequency, duration of CC and number of care-givers were obtained and analyzed. The results of the study showed that therapeutic effectiveness was diminished when relief nursing staff acted in an intrusive manner; the transition from CC to close observation was poorly managed; the personalities of the nurses were more significant than the skills they possessed; patients preferred nurses of the same gender; and, patients were able to identify specific nursing acts that were particularly helpful. In terms of administrative concerns, off service casual staff and security guards were not valued; the night shift had multiple problems and lack of continuity of care proved to be irritating for the patient. The nurses viewed CC primarily as a negative experience; the patients as a positive experience. Others, including family members, doctors, clergy influenced the nature of the CC tenure. The alternatives to CC included a different system of observation, alterations to the environment and good nursing care. This is the first descriptive study of CC and clearly demonstrates the value of having nurses and patients describe their CC experience.

PREFACE

Please note:

To avoid sexist language the nurse is referred to as either he or she rather than just she; the patient is referred to as either he or she rather than just he.

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There are so many people who have helped me directly or indirectly in completing this thesis. I would like to acknowledge the following:

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CHAPTER I

WHAT IT IS?

The research study is a collection of descriptions given verbally by patients and nurses. The following description crystallizes the purpose, significance and implications of giving oneself totally to another person regardless of the situation. It is told in Donna's own words:

> I was doing casual at that time, and I came in and did a shift. John Peter, this fellow had moved up north from Winnipeg. He was an accountant and he and his family were in a terrible car accident where his wife was killed and two little boys. He and his wife had come from U.S.A. and so they just were going to make a fresh start in a new country. And this happened, so he did what a lot of people do, he went up to Yellowknife, took a job as an accountant up there. And then soon started hallucinating and withdrawing and hearing his wife and boys, and was brought down here. His goal was to jump off the High Level bridge when he got here because he --there was just no way he wanted to live anymore. And when I looked after him, he would bodily just turn away from you, and he was mute, he wouldn't say a word to you. And I set up this plan of care where I--I went through this routine that I set up, doing his morning care, and he was quite resistive to it. But I even ended up--I gave him a backrub because he --he didn't really want me to, it looked like a first, but then he seemed to relax when I was giving him a backrub, so I rubbed his feet. He wouldn't even-like, when I'd say good morning each morning, tell him who I was and that kind of thing, I would get nothing from him. And he wouldn't eat or drink, and they were thinking about putting IVs in. But after the third day, going through this kind of ritual, he turned around--it was Sunday morning, on a weekend. And he turned around and said, "I'd like to go to church this morning." So he didn't have an order for going to church because constant's can't go off the ward, so we phoned the doctor--or one of the staff did, and they did get an order from him to go down to church, and when he got down to the little chapel there, he sat right behind a resident, his wife and two boys. He was just moving, just fidgeting, he couldn't sit still. so I--I said to him "you know, John, you seem very--you, know, you're moving around a lot, this is very-obviously very uncomfortably for you. Would you like to go back to the ward? And he said, "no." So we sat through the service, and that's the way he

went all through the service, just moving constantly. And he didn't get up right away to leave, so that everybody was pretty well out of the chapel when we finished. And then when we walked out to the front just got out through the chapel he said--turned around to me and said, "I'd like to go for a walk." And he said it in such a way that I knew that he--you know, he was right at the point where he was making a decision. He was either going on his own or I'd--I just had that feeling, if I didn't go he would be gone anyhow. And there wasn't a phone down there at the far end or anything, and he just headed off on me. So I followed him, and he was just about on the run. So I kept saying, "you know, this is-is this the first time you've been in church since you buried your wife and two little boys?" And he finally said, "yes," and I said, "tell me about that, tell me about the funeral," you know, and we got talking about this. So he finally started telling me, and I asked him what their names were, and we went on, and he kept talking about this funeral and how terr-like, how he wanted to kill himself and that kind of thing. And we were just literally running, eh, like for me to keep up to him. But we went--I knew the city a lot better than he did, I took him the opposite direction of the river. And went over around the old normal school and came back, and we got to the front door, and I was just worried sick because I knew that staff would not know where we were, and we hadn't arrived back. But anyhow, we got back, he didn't take that long. And he just said, "thank you very much." He said, "you know, I could never have done that." He said, "I needed to talk but I couldn't get started because I felt so closed in on the ward," and he said, "as soon as we got outside and--it seemed like it was easier then for me to get--this out, eh?" So that was--it turned out to be a very positive experience.

"Constant Care" (CC), "Constant Observation" (CO) or "Specialing (S) are terms used in psychiatric facilities to describe the mandatory continuous attendance to a patient by one nursing staff member. For the purpose of this research project, the term Constant Care (CC) will be used since an inference can be made that <u>care</u> is given, whereas constant observation (CO) denotes detachment, and Specialing (S) does not ensure the continuous or constant presence of a nurse. When a nurse gives CC she is assigned the care and observation of one patient and has no obligations to other patients or unit administrative responsibilities. Patients who

require CC are usually those who are suicidal, very aggressive, acutely psychotic or physically debilitated. Occasionally newly admitted patients are placed on CC so their behavior may be fully assessed.

Constant care is one part of an observation system, which is similar in most psychiatric facilities. All systems include a maximum level of observation called "Constant Care", and a minimum level "General Observation", which is in place for patients who are relatively stable and trusted to follow the treatment plans and not to harm themselves or others. Intermediate levels such as "Close Observation" or "Intensified Care" imply that the nurse checks the patient every 15 to 20 minutes depending on the policy in the institution.

CC is a fairly recent practice for psychiatric nursing staff. In the early to mid 1900s, patients who were considered dangerous to themselves or others were simply kept on locked units. If their behavior could not be controlled they were placed in a locked cell as a way of minimizing the risks to the patient, nursing staff and others on the unit. The discovery of phenothiazines to control aggressive and psychotic behavior ushered in a new era in psychiatric management of patients. As well, mental health workers began to emphasize the benefits of therapeutic relationships, and patients were gradually released from locked units (Beck, Rawlins & Williams, 1984; Stuart & Sundeen, 1983). The liberalization of institutional controls and legislation which supported rights and privileges for psychiatric patients, also contributed to the substitution of CC for patients rather than placing them in isolation (Phillips, Peacocke, Hermonstyne, Rosales, Rowe, Smith, Steel & Weaver, 1977).

In the 1980s many patients with mental disorders are admitted to active treatment general hospitals where psychiatric care is but another service in the comprehensive health care offered by the institution. The isolation of individual psychiatric patients in locked rooms is incongruent with the voluntary nature of the patients' admission to these settings or with society's increased belief in patients rights and advocacy in psychiatric care. The use of locked isolation rooms is now an inferior management strategy for control or confinement of patients. Isolation provided some safety but CC provides an opportunity for skilled observation of patients and for the development of therapeutic relationships. Patients can be provided with excellent physical and emotional care and under certain conditions where the skills of the nurse and the condition of the patient are compatible, the patient is guided toward recovery.

Purpose of the Study

The purpose of the study was to investigate the meaning of CC to nurses and patients using a descriptive qualitative method. They were interviewed using a semi-structured questionnaire to determine their perceptions of the experience, its purposes and values.

Significance

CC is a demanding, challenging and expensive nursing intervention which is used routinely on psychiatric nursing units. It is therefore surprising that so little is known about it from administrative, nursing or patient perspectives. Assumptions are made that CC is a therapeutic

intervention and mandatory for maintaining a safe environment. What is not known, is the meaning it has for the nurse or the patient. For example, if a nurse dislikes giving CC, then her constant presence with the patient could be antitherapeutic or if a patient is sensitive to maintaining a sense of privacy, the constant presence of the nurse could also be viewed as invasive and antitherapeutic.

The significance of the study is broader than gathering descriptions of nurses and patients' experiences of CC. As a sample, nurses and patients are available participants, but it is hoped that the findings will have import for all helping professionals. Aside from understanding what happens between care givers and care receivers, much can be learned about how to facilitate and enhance the helping relationship. Care recipients, in this case patients, should be able to articulate ineffective and effective care giver behaviors. Likewise, experienced care givers, in this case nurses, could teach novice care givers strategies to help them be more therapeutic.

Key Terms

Constant care. CC is the provision of continuous nursing attendance and observation to a patient. It means a staff member is assigned to be with that patient at all times and will have no other assigned duties.

Patient. A male or female adult admitted to a hospital. If placed or transferred to a psychiatric nursing unit, a psychiatric diagnosis is implied.

Nurse. A graduate of an approved nursing educational program and registered to practice in the province of Alberta.

Perception. A process by which sensory stimuli are organized and given meaning as the person identifies and describes his environment. It involves sensation of, feelings about, and interpretation of or the meaning related to an event in its totality (Murray & Heulstoeffer, 1983).

Conceptual Framework

Among the behavioral sciences the field of social psychology provides a conceptual context for studying CC. In the words of Hollander (1976), social psychology "emphasizes the part the individual plays in social relationships, and it focuses on understanding the processes underlying these relationships" (p. 30). Social psychology addresses the study of the effect of social influences on individual processes, examples being learning, perception and motivation; the study of shared processes such as language and social attitudes; and the study of group interaction which includes social roles, power relations, leadership, competition and conformity and communication (Shaw & Costanzo, 1982).

Of the many theories spawned by the social psychologists, role theory constitutes the best orientation of CC. It has been defined in various ways with the commonality among definitions being that a role "is a pattern of social behavior or set of behavioral expectations (norms) which are organized around a given function and performed in a social (interaction) system" (Vander, Ernst & Sallinger, 1979, p. 23). The underlying propositions of role theory, are:

1. There are certain behaviors that are patterned and can be labelled as characteristic of people in a given context;

2. People who share a common identity also share similar roles (social position);

3. People are aware of roles and will govern their behavior to accord with their role expectations;

4. People are taught roles and accept or reject the roles they are expected to use;

5. Individual roles are part of a larger group or social system;

6. Roles maintain a place in society because they are functional. (Biddle, 1979)

Shaw and Costanzo (1982) have identified eight characteristics of a good theory. It must be internally consistent, testable, simple, economical, consistent with related theories, readily interpretable, predictions of the theory must agree with known facts and, lastly, serve a useful purpose. Heines quoted in Biddle (1979) makes the following statement about the merits of role theory:

> Role theory has a splendid neutrality . . . . the importance of role theory is undeniable, its range of influence has been vast, research engendered in its name diverse and bountiful and it has a remarkable specificity for our times. (p. 1)

Role theory does have a set of terms and concepts which describe many events of interest to the social sciences. It is easy to understand because it is so well defined and versatile in its application to individuals and groups. As part of a methodology, it is neutral and has been used by social scientists employing participant observation, questionnaires and projective tests. As well it is a theory that has been useful in providing a conceptual framework when doing qualitative research.

Role theory, however does have drawbacks. Multiple definitions and conceptual ambivalences have resulted from different interpretations of

terms and concepts. Biddle (1979) observed that the theoretical statements were often obscure and the theory lacked propositional organization. The very simplicity and economy of the theory is also its weakness. It is a limited theory because it can not account for an individual's creativity or ability to evolve new roles.

Even with its flaws it can be used to understand and research highly structured institutions like hospitals. To illustrate this point, consider that the patient is given a role as is the nurse who is aware and responsive to the person (patient) and his role as a patient. The relationship between the nurse and the patient are structured: the nurse expects the patient to act in a role - appropriate manner and vice versa. Both the nurse and the patient exhibit certain behaviors which can be described as their role performance. Evaluation of the nurse's and the patient's roles, based on normative expectations, is called sanctioning. Sanctions may be positive or negative, covert or overt. The nurse and the patient are members of reference groups and each experiences normative pressures to maintain their membership in their reference group. Position is a term used to describe what place the nurse or the patient holds in the social structure of the nursing unit. Role conflict occurs when the patient or the nurse does not behave as expected for that role; or, when the position they hold is incompatible with another they are expected to hold by self or others.

Role Strain

Role theory views the person as a whole, who exhibits behaviors that are comparable, identical or distinct from others. A person's behavior

impacts and affects others in positive and negative ways. When a person experiences role strain it is due to their perceived inability to fill their role obligation to others. The major cause of role strain may be contradictory expectations in a role - "as a nurse I want to trust you but when you are on CC, you are not trustable"; role accumulation - "as a nurse I have to sit CC but I have three other primary patients"; working in rigid time frame - "as a nurse I must be with you for the following eight hours"; being constricted by space - "when I have to nurse a patient on CC I can not leave the unit;" and, the level of activity required for a role -"since you are a manic CC patient I must set a limit on your behavior every five minutes". Other causes of role strain may be feeling uncertain, incompetent, overqualified and bored. As a result of role strain, a person may feel frustrated, fatigued or embarrassed. The end result is not always negative, a person who has felt incompetent may improve on their skill level and enhance future performances (Ward, 1986). One dimension of role strain is very fitting for CC and that is the concept of role captivity. Essentially a person is caught in an escapable obligation to do one thing while desiring to do something else. A nurse may be giving CC while desiring to be with a number of patients or a patient may be given CC while desiring to be left alone.

Sick Role Theory

Role theory, through the pioneer work of Parsons (1951), provides a framework to study illness and consequently patients.

Parsons developed behavioral presumptions of the sick role. As listed, they are:

1. An exception from normal social responsibilities;

2. The recognition that because the patient is legitimately sick, he cannot be expected to get well by "pulling himself together" by an act of will;

3. The expectation that the patient accepts the state of being ill as undesirable and assumes the obligation to get well;

4. The obligation to seek technical competent help.

Parsons viewed sickness as a form of deviance, but less harmful to society than other forms of deviance such as crime or certain political allegiances. The sick role is a method of escape but through resocialization with the help of the medical profession, the patient is able to emerge from the sick role, accept his normal place in society and become functional again (Conners, 1983).

Parsons has been criticized because he does not distinguish between actual behavior and what Vincent (1975) calls Parson's "oughts" of behavior. When saying how a patient ought to behave in the sick role, the theory becomes biased and nonspecific. Also, when it is assumed that a patient will be motivated to get well, it begs the question of chronic illness or self destructive behaviors (Mayou, 1984). Lastly, Parsons has not really addressed the temporal dimension of illness since it occurs in multiple stages from sign and symptom formation to complete recovery (Hover & Juelsgaard, 1978).

To illustrate the utility of the sick role theory, two research studies which used it as a conceptual framework when studying psychiatric patients, will be briefly discussed. Hall (1975), referring directly to the work of Parsons, examined the psychiatric sick role socialization

process through the use of participant observation. She found that the therapeutic role expectations were not clearly defined, nurses needed to reduce their role conflicts and needed to develop criteria to evaluate role expectations. In the second study, Vander, Ernst and Salinger (1979) administered the Psychotherapy Expectancy Inventory to 30 psychiatric male patients divided into two groups. The findings were startling because the patients wanted approval and advice from the staff, whereas the staff wanted the patients to be self directed. In other words the patients wanted a guidance model and the staff a mutual participation model. In both studies, the use of role theory helped the researchers determine the role positions of the patient and the staff and in turn provided a rationale for implementing program changes.

In this study, the sick role for the CC patient is legitimate, learned, but viewed as temporary. The patient, at some level of awareness, recognizes he is ill and desires to get well. The label of CC places her formally in the sick patient role and since she has not experienced this role as a nonpatient, her reflections and description of the role will be invaluable for improving patient care. The nurse, too, has a role to perform. Since he is not ill but coupled closely with someone who is very ill, his behavior will be changed due to the interaction. The meanings he ascribes to the role will be useful in guiding others to view the giving of CC in a therapeutic manner.

CHAPTER II

WHAT IS KNOWN?

CC, as a focus of the study, has not been widely researched. The review of the literature addresses what is known about CC through review of theoretical and research articles, as well, addresses four other indirect but related areas. As listed, they are: territoriality, aggression, alternatives to CC, and psychiatric patients' perceptions of hospitalization. The review of the literature was a continuous process. It began before the research questions were formulated and continued throughout the project, ending only with the writing of the dissertation.

Theoretical Positions

In reviewing the psychiatric nursing articles that have been written about CC, four issues were identified: when is CC appropriate, what are the roles and responsibilities of the nursing staff when administering CC, what is the response of the patient, and what are the alternatives to CC? CC is appropriate when the patient is a danger to him/herself or others and requires external control. It is a means of forming a therapeutic relationship, gaining pertinent information about the patient's condition and decreasing the patient's anxiety about his illness and presence on a psychiatric unit (Blythe & Pearlmutter, 1979; Moran, 1979; Phillip et al., 1977; Yonge, 1985). Patients who are very ill, physically and emotionally, require continuous attention by highly skilled nurses because of variable body responses, high doses of medications and the need for

immediate medical and nursing interventions. The patient's behavior is such that a nursing staff "know" and readily articulate that the patient has to be on CC.

Nursing staff are not always clear about their roles and functions while giving CC. Moran (1979) notes that CC is at times given ritualistically in a custodial manner. Briggs (1974) states it may be used punitively as a way of controlling disruptive behavior and disobedience. CC may be stressful for nursing staff, particularly when they are unable to care for other patients with whom they have developed therapeutic relationships. This may result in feelings of frustration and guilt for the nurse. These feelings are accentuated if the patients are reproachful because their nurse cannot care for them that day. As well, if the patient receiving CC is aggressive and unpredictable, the nurse may feel tense, angry and fearful. Furthermore, if the nurse believes that her care is inappropriate or ineffective for the patient, she may feel resentful and angry at the patient (Moran, 1979; Yonge, 1985).

Patient reaction to CC may be either negative or positive. Patients may feel relieved that the limits are set on their behavior, continuous guidance and support is being offered and some may enjoy the continuous attention (Moran, 1979). Difficulties arise when the patient feels a loss of privacy, is restricted, punished and/or has feelings of powerlessness (Schuster, 1973). If the patient perceives that he is a "chore", "nuisance" or "burden" to the nurse giving CC, he may react abusively or further regress. Since the basis of a nurse-patient relationship is trust and being on CC communicates mistrust, the nurse and the patient are essentially stalemated in the formation of a therapeutic relationship.

Moran (1979) recommends using a behavioral checklist to replace CC, whereby everyone on the unit is observed and their behavior recorded on a 17 item checklist every half hour on all shifts. The objectives for the checklist were:

> to maintain a safe environment for all patients; to decrease the number of patients on constant observation; to utilize nursing staff with the greatest efficiency; to increase patients' responsibility for their own behavior, and to increase nursing staff's observational skills, (p. 114)

The use of the checklist was evaluated as very successful as it resulted in a dramatic decrease in constant observation hours, greater freedom for the patients to come and go, increased confidence in nursing staff's ability to assess and make decisions, and increased feelings of security in patients and nurses. An unexpected advantage was the use of the checklist as a feedback mechanism for patients to show them how their behavior had changed over a period of time. However, the checklist may not be openly adopted in other psychiatric institutions. Factors such as severity of the patient's illness, predominance of physical signs and symptoms, medical interventions used and the complement of available nursing staff may necessitate the actual physical, continuous presence of a nurse. As well, using a checklist may have legal implications if the patient harms himself or another between checks.

Research on Constant Care

It has been surprising that an expensive, stressful intervention such as CC has been afforded so little formal research attention. Through the use of a computer literature search (Bibliographic Retrieval System)

and a hand search, four research studies, two pertaining directly and two indirectly to CC, were obtained.

The most recent study, conducted by Goldberg (1987) surveyed 118 New England general hospitals with 90 or more beds, to determine whether the hospitals had a written policy governing the use of CC with suicidal patients, how frequently it was used and the effect it had on staffing patterns. The researcher found that 30 percent of the hospitals did not have a policy to initiate CC and, of those hospitals that did, two-thirds allowed nurses to initiate CC. However only ten policies specified who could discontinue CC, 14 policies specified the qualifications needed by staff members, 22 policies outlined the observer's role and 23 policies addressed the need for the patient to have a safe environment. The researcher concluded that there were no significant trends in the use of CC in regard to size of hospital, that, although 92 percent of the hospitals used CC, very little statistical data was available and policies governing its use were inadequate. Some hospitals used families and volunteers to give CC, which seems to defeat the purpose of caring for very ill patients, and finally the initiation and discontinuation of CC by different disciplines created a problem with accountability. The greatest limitation of the research was that all patients in a general hospital who were potentially suicidal were studied making it difficult to generalize the results to a psychiatric unit, where all patients are potentially suicidal, yet a small percentage are placed on CC.

A second current study conducted by Aidroos (1986) did not focus on CC but on the next observation level of close or intensified care. With this care a patient does not have a nurse constantly but is checked every

15 to 20 minutes. Aidroos found that not one nurse followed the doctor's orders of giving close care but instead made their own assessments as to what the patient required. This meant that some patients received close care when none was ordered or general care (checked every hour) when close care was ordered. The implications of the study were that nurses did not require a doctor's order for close care, just for CC, and that the policies should be changed to reflect the actual practice.

Phillips et al. (1977) completed a retrospective study on CC at the Clarke Institute in Toronto, Ontario for the period of 1966-1976. Old charts of 200 patients on CC were studied and a questionnaire was distributed to the nursing staff soliciting their opinion about the therapeutic benefits of CC. The findings were used to develop a composite picture of the CC patient. The patient was more likely to be female than male, diagnosed with schizophrenia or depression, Canadian born and placed on CC for suicidal intentions. The main purpose in providing CC seemed to be in providing a safe environment. Seventy-five percent of the nursing staff were dissatisfied about giving CC. At the time of the study each staff member spent one hour with a CC patient because giving CC over a 8 hour shift was viewed as too stressful. Consequently the staff considered CC to be custodial rather than therapeutic in nature. Given this finding the researchers correlated the hours of CC with staff sick time and found a statistically significant correlation: staff sick leave time increased after doing a high number of CC shifts. The research study highlighted the effect of CC on the staff attitudes and provided evaluative data to implement changes in that institution.

The first study on CC was conducted by Briggs (1974) who submitted a questionnaire to patients and staff asking them to describe their attitudes and beliefs about CC. The results were important because both the nurses and the patients viewed CC as negative and custodial in nature. Patients alleged that CC was often used for punitive reasons, an example being the control of disruptive behavior, and, nurses employed CC as a ritual to alleviate anxiety among the staff.

The research studies on CC are helpful in obtaining research directives as reflected in the following two quotes:

> further studies on the therapeutic effect of continuous observation in terms of staff - patient interactions and the patient's response to this type of care are indicated (Phillips et al., 1977, p. 27)

and

> further studies should consider the use of constant observation in relation to other management methods such as restraint, seclusion, and psychotropic medications. They should also examine constant observation in practice and its use in situations not involving suicidality (Goldberg, 1987, p. 305).

The analysis of the existing research also indicated that patients' perceptions have not been fully explored, that, although nurses' have negative attitudes toward CC, the reasons for their attitudes have not been elicited through interviews and, being a highly intense, expensive intervention, it warrants further research to increase knowledge about its therapeutic efficacy.

Territoriality

Consideration of the patient's and nurse's sense of physical space is part of the CC intervention. Territoriality has been described as, "a state which is characterized by possessiveness, control and authority over an area of physical space" (Hayter, 1981, p. 79). The function of territoriality is to provide security, privacy, autonomy and self-identity. Specifically this means a person will feel safer, less anxious, more confident and expressive when in his own territory. Other features of territoriality are: the smaller the territory the more important it becomes (Bigbee, 1984); the greater the status of an individual the more territory they can demand (Hines, 1985); respect for territory among humans is through mutual avoidance of each other's spaces (Johnson, 1979) and when a person is in his own territory he will be stimulated, motivated to question and to deal with problems, however outside of his territory, he may be meek, passive and uncertain (Hayter, 1981).

The concept of territoriality has been researched using patients and staff as subjects. Kerr (1986) observed staff on four medical-surgical units and concluded that the status difference between doctors and nurses was strongly associated with a greater physical distance between them as compared to the physical distance between doctors and conversely the physical distance between nurses. In an earlier study, Kerr (1985), using the same site, found that freedom of movement and use of private space was also associated with status. Geden and Begemen (1981) reviewed research on patient's personal space and reported that the longer the patient was in the hospital, the smaller became his personal space preference; male schizophrenic patients had a greater personal space preference than normal

males; and, female psychiatric patient's approach distances were larger than males. This latter finding was related to the fact that males tend to have a territory in their homes that is reserved for them alone and females do not have this privilege. Females may claim the kitchen as their space, but everyone is free to share the space with them.

Smith and Cantrell (1988) studied the emotional and physical reactions of 40 schizophrenic patients when their personal space was violated. They found that the verbal content of an encounter could be more intrusive than a body being positioned in the patient's space. Using a pulse monitor, they also found that a physiological measure was more sensitive to the patient's actual arousal state than a subjective rating scale. The difficulty with their research is that it blends a verbal interactive model with a physical space model and so the results are questionable. Another study that also had design problems asked 60 patients to place figures on paper according to their personal space preference. The patients ranked their preference for physical closeness in the following order: relatives, doctors, nurses, strangers. The difficulty with the findings were that nurses and strangers were not identified by one name, whereas the relative and the doctor were identified as familiar singular reference points (Geden & Begeman, 1981).

One aspect of territoriality that bears closer examination is the concept of privacy. Privacy means the ability to control access to information, having the right to be alone and being able to control access to space. The functions of privacy are to regulate self-other boundaries and, in doing so, to establish one's self-identity (Kerr, 1985; Rawnsley, 1980). Kerr (1985) argues that if a person's right to privacy is denied

he will create territories or try to control his space. In the hospital setting a person could create his territory by arranging furniture, placing personal articles in obvious places and spending time on their "furniture" (Hines, 1985).

A patient on CC would be vulnerable in having his territory and consequently his privacy invaded. It would be important for the nurse to understand this vulnerability and to suggest concrete measures to the patient to enhance his sense of territory. For example, the nurse could avoid eye contact when a patient is eating, allow the patient to change with his back to the nurse, or clarify with the patient how the furniture should be arranged for the patient's comfort.

Aggression: A tie between nurse and patient

Any patient who is aggressive and consequently assaultive is a potential CC patient. This section will review the literature on staff's responses to assaultive behaviors, types of patient aggression and methods that have assisted staff in dealing with their feelings of victimization. There are two types of aggression: physical aggression, which is any behavior that results in bodily harm to another or destruction of property; and verbal aggression, which is composed of threats or gestures which evoke feelings of fear in the staff. The majority of the articles reviewed used the word assault to refer to a patient's aggressive behavior and did not describe whether it was verbal or physical.

Conuit, Jaeger, Pin Lin, Meisner and Volvavka (1988) identified four patients' behaviors that will increase the likelihood of a patient being assaultive. As listed, they are: deviant family background, being

convicted previously for a violent crime, having a history of violent suicide attempts, and displaying seizure disorders or other neurological disorders. Based on these identifiers, they developed a statistical model for predicting assaultive behaviors using logistic regression analysis. Studying a matched sample of 87 assaultive and non assaultive psychiatric in-patients, they found the four identifiers to be valid and reliable.

Brizer, Conuit, Krakowski, Volvavka (1987), claiming that violent behaviors in psychiatric hospitals are significantly under reported, developed a rating scale for reporting violence. During a four month observation period, a researcher using the rating scale, documented 444 violent events where as the staff only recorded 281. This finding has implications for nursing staff's reactions to aggression. Obviously staff underreact to aggression and consequently do not receive sufficient support for their feelings of victimization. Lanza (1984) did a follow-up study of 99 nurses who had been assaulted. Although the nurses experienced an intense reaction to being assaulted, they were reluctant to discuss their feelings. Fifty-five percent "needed" and 32 percent "wanted" to talk about the assault but did not. Lanza explains that this behavior resulted from a perceived role conflict, that of being a victim and a care-giver at the same time.

Dawson, Johnston, Kehiayan, Kyanko and Martinez (1988) elaborate on the dynamics of the staff's role conflicts. Being a victim means the staff member will feel vulnerable and develop a negative self image. If the assault is minimized in the mind of the staff member, he will be able to deny his feelings and accept blame for the incident. Not only will he accept blame, but his co-workers and family members may blame him also.

However, the staff member also may feel angry and enraged at the patient, while cognitively accepting blame and moving from the role of victim to care-giver, thereby communicating two messages to the patient. The staff member, to cope with his feeling, may become overly defensive and punitive (Maier, Stavou, Morrow, Van Rybroek & Bauman, 1987). Podrasky and Sexton (1988), examining nurse's reactions to difficult patients, found that the nurses will take out their anger towards the patients on a third party if they can not use avoidance as a coping mechanism. The researcher also had some serendipitous and unsettling findings when 19 of the 73 subjects wrote unsavoury statements in response to a vignette. For example, one nurse wrote that she would say to a difficult patient "You're an asshole and deserve to be in pain" and another wrote "I'd tell him to go to hell." The researcher could not explain the findings and hoped they were an anomaly.

Gallop and Wynn (1987) interviewed 25 patients and 12 psychiatric residents (doctors) asking them to describe difficult patients. The findings pointed to patients who alternate between help seeking and help rejecting and are labelled as high energy-high demand types. These patients create feelings of frustration and anger in staff. In the findings, nurses differed from doctors in their affective responses; the nurses had highly personalized responses, whereas the doctors were able to distance themselves from and objectify the patient's undesirable behavior. The two major concerns of both the doctors and the nurses were lack of control and incompetence. Groves (1978) in an interesting article called "Taking care of the hateful patient" discusses how certain patients evoke undesirable thoughts and feelings in doctors. In his framework, the

dependent clinger promotes feelings of aversion, the entitled demander feelings of fear and counter-attack, the manipulative help-rejector feelings of guilt and inadequacy and the self-destructive denier feelings of malice and a secret wish that the patient will "die and get it over with" (p. 887). It is clear that patients' and staffs' negative feelings affect each other to the detriment of both, even including family members.

To counteract the negative effects of aggressive behavior and to prevent assaults, Felthous (1984) recommends that psychiatric units establish a norm against violence. The norm would be communicated through orientation manuals and ward meetings and would be the responsibility of all staff and patients. This would mean that co-patients would be aware of how to defuse a potential hostile event and, if they too engaged in scapegoating of certain patients, limits would be set on their behavior. Infontino and Musingo (1985) devised a three day training program on how to control patient aggression for staff in which 32 of 96 staff members were trained. After a two year period, they found only one staff member of the trained group was assaulted compared to 24 in the non-trained group. As well, 19 of these 24 were injured. They attributed these significant findings to the change in attitude of the trained staff, who were more relaxed and confident in their abilities to manage aggressive patients.

Dawson et al. (1988) described another useful method to help staff. Recognizing that victimized staff often feel neglected and unsupported after an assault, they formed an Assault Support Team. To become a member of this team, staff were required to take a weekend training course which focused on the dynamics of assault, expected victim responses and required

supportive interventions. These interventions involved a member of the Support Team contacting and reviewing the assault with the victim immediately after the event. To ascertain the benefits of this intervention, a questionnaire was sent out one month after the assault. Seventy-one percent of the staff reported they were very satisfied with the support they had received from the team member. The researchers also noted that, after the implementation of the Assault Support Team, there was a significant decrease in staff turnover.

This section has highlighted the interactive feeling effects between patients and nursing staff. When patients are aggressive they must be responded to in a therapeutic manner - firm, calm and accepting. However, when staff feel victimized, they can not be therapeutic. Training and support programs should be mandatory for staff working with aggressive patients if standards of care are to be maintained.

Alternatives to Constant Care

Patient's harmful behaviors to self or others can be managed through the use of seclusion rooms, locked units, mechanical restraints (vest, wrist and ankle) or chemical restraint. The application of any of these strategies is dependent on the nature of the patient population, philosophy of the care-givers and physical environment of the institution. The use of chemical restraint is available for all psychiatric patients unless they are on a drug free research unit, undergoing special testing or require observation to formulate a diagnosis.

Seclusion, a fairly common but controversial practise, varies in incidence from 4 to 66 percent (Richardson, 1987). It is a form of

external control whereby a patient is placed in a locked, physically bare room for a duration of 30 minutes to several hours until his behavior is deemed as controlled. The usual policy is for a staff member to check the patient every 15 minutes through a viewing window, but staff may sit outside the room continuously or may even spend short periods of time in the room with the patient. Proponents of the use of seclusion argue that it decreases provocative stimulation and allays anxiety, while opponents argue that it violates patient's rights and is too restrictive an environment (Richard, 1987; Wadeson & Carpenter, 1976). Grigson (1984) claims that seclusion is not successful on a long term basis and the very use of it communicates to patients that the staff will accept the full responsibility and management of the patient's impulsive behavior.

Frequency, patient profiles, attitudes, size of institution and impact of seclusion have been researched through the use of questionnaires (Carpenter, Hannon, McCleery & Wanderling, 1988; Ransohoff, Zachary, Gaynor & Hargreaves, 1982; Soliday, 1985), art therapy (Wadeson & Carpenter, 1976), interviews (Binder & McCoy, 1983; Richardson, 1987), and a pre-post design studying the effects of a change in institutional policy (Davidson, Hemingway & Wysocki, 1984). The results pertaining to patient and staff attitudes and reactions to seclusion are most significant in viewing it as an alternative to CC. Binder and McCoy (1983) interviewed 24 patients within one week of being secluded and found that most of the patients did not know why they had been secluded, half of them viewed it as a negative, anxiety-provoking experience, and they saw it as a last resort. Wadeson and Carpenter (1976) decided to research the use of seclusion when a third of their patients included direct references to it

in their art therapy sessions. They concluded that many of the patients had pleasurable visual hallucinations (due to sensory deprivation?), terrifying delusions, negative reactions to staff and a depressed affect while in seclusion. Of interest in this study was the use of a one year follow-up art session. After one year, patients still recalled the seclusion experience with bitterness and for some it negatively coloured their entire perception of hospitalization. Richardson (1987) interviewed 52 patients, half of whom recognized that seclusion protected themselves or others. Fifty percent stated that they had not needed seclusion but instead a different approach from the staff.

Staff attitudes toward seclusion differ from the patients'. Generally staff believe that seclusion is helpful in calming the patient and providing a safe, effective treatment (Grigson, 1984; Heyman, 1987; Ransohoff, Zachary, Gaynor & Hargreaves, 1982). Soliday (1985) researched patient and staff attitudes using the same questionnaire, because the differences between the staff and patient's attitudes toward seclusion in previous research could have been artifacts of the experimental design, and since patients and staff had been asked different questions about the experience. He concluded that the two groups had very discrepant views on seclusion and that staff members were unaware of the great impact seclusion had on the patients. Patients saw it as more harmful, including those who had never been secluded. He hypothesized that patients had a greater pessimism because they were forced to play the role of the patient. They had no choice but to do as the staff demanded, no matter how undesirable it was.

Restraints, like seclusion, are used to provide physical security, protection, limit movement and control behavior. Negative consequences of the use of restraints are increased rate of falling, accidental strangulation, loss of self image, increased confusion, dependency, disorganization and regression. Others view the restrained patient as dangerous, disturbed and mentally incompetent. Strumpf and Evans (1988) interviewed 20 patients who had been restrained (mean of 23.3 days) and 18 nurses, using the Subjective Experience of Being Restrained Instrument for the patient and the Restraint Use Questionnaire and Primary Nurse Questionnaire for the nurses. The patients and nurses differed significantly in their perceptions of reasons for restraint; the most frequent reason the nurses gave was altered mental status, whereas the patients cited safety. Over half of the patients expressed negative feelings such as anger, fear, resistance, humiliation and discomfort. When nurses and patients were asked for alternatives to restraint, the patients cited 11 which included easier access to the bathroom, more diversional activity and complete discharge from the hospital; while the nurses cited a limited number or none.

Davidson, Hemingway and Wysocki (1984) researched the frequency of use of seclusion, restraints and medication to control behavior before and after institution of a policy to decrease and hopefully eliminate the use of these restrictive procedures. The use of seclusion was decreased by 99 percent, restraints by 88 percent and medications dropped from 36 percent to 20 percent. They attributed their success to the following: weekly posting of feedback sheets indicating the use of restrictive procedures, the population of the institution decreased from 883 to 630

so residents had an increase in living space, and a decrease in drug use resulted in a decrease in assaultive behaviors for patients who did not respond to medication. The new drug free patients increased in their learning abilities and responsiveness to programs. The research gave credence to operant conditioning, addressed in part the relationship between the crowding factor and emotional responses of patients and challenged staff to assess patients and non responsiveness to medications.

The current philosophy in care of the mentally ill is to restrict as little as possible (Garritson 1987). The use of seclusion and restraints, be they chemical or mechanical, appear to be more harmful than helpful and more than less restrictive. Patients, when asked about their reactions to this form of restriction, have significant negative reactions which are sustained past the hospitalization period. It would seem prudent to use these measures only as a last resort. Constant care, while also restrictive, is less so and so appears to be a more humane, caring alternative.

Psychiatric Patients' Perceptions of Hospitalization

Researchers have used a variety of methods to study the experience of being a patient in a psychiatric hospital, including measurement of satisfaction by: spending time on a psychiatric unit as a patient for research purposes (Rosenhan, 1973); describing personal observations as a clinician (Hall, 1975); using questionnaires (Dowds & Fontana, 1977; Klett, Berger, Sweall & Rice, 1963); interviewing (Allen & Barton, 1976; Kotin & Schur, 1969; Lee, 1979); and, using rating scales (Robinson, 1978). Patients have also published articles about the experience of

being a psychiatric patient (Chamberlin, 1985; Colvin, 1978; Maxon, 1974) and submitted letters describing their hospitalization (Eisen & Grob, 1979). It is difficult to generalize from the findings of the research projects because they are institution specific and measure different but related variables (attitudes, treatment outcomes, experiences, relationship). The other factors, such as the physical environment, diagnostic composition of the patient sample, religious or non-religious affiliation of the institution, also influence the findings of each research project. Furthermore, when researchers are attempting to measure patient satisfaction, they must consider multiple variables such as the patient's personality, experiences, expectations, philosophy, length of hospitalization and diagnosis (Kalman, 1983; Piersman, 1986-1987; Urquhart, Bulow, Sweeney, Shear & Frances, 1986-1987). Kalman (1983) reviewed 57 articles on patient satisfaction and concluded that most research studies did not use standardized instruments, the comments of non-respondents were more informative than those of respondents (since effective treatment is not always appealing to the patient) and the patient's perception of the need to be positive always presents a problem with bias.

Weinstein (1981) surveyed a number of quantitative studies measuring patient's attitudes, completed between 1959 and 1979, and found that patients were quite positive about staff (doctors and nurses) accessibility, support, training and receptivity, but were "critical of staff's control over them, enforcement of hospital rules and a lack of permissiveness for expressions of anger or aggression" (p. 487). This latter finding has implications for CC since the intervention could be

viewed as a control which is instituted when the patient may be a danger to himself or others. As well, the diagnosis of dangerous may be associated with covert or overt aggression.

Allen and Barton (1976) interviewed 95 psychiatric patients about their attitude towards hospitalization at 3, 6 and 12 months after discharge. They found the patients commented on four main categories: relationships, treatments, physical environment and disposition. The patients generally had negative comments about all the areas except treatment. Even in the latter category, patients commented negatively about medications and group therapy. Allen and Bartons' findings contradict Weinstein's findings, which may be due to the specific institution chosen as part of the setting. Also, since the interviews were done post-discharge, the patients may have had a difficult time recalling specific positive and negative experiences and so gave a general impression, which happened to be negative. Recently this finding was supported by Drake and Wallach (1988), who surveyed 187 discharged patients and found that less than 24 percent preferred the hospital. Another study completed by Kotin and Schur (1969) found that patients complained about the physical environment, poor food, crowding, understaffing and a marked lack of privacy.

Osofsky and Fry (1985) conducted a patient discussion group which met once per week over a three year period. The goal of the group was to explore the patients' perceptions of the experience of being a psychiatric patient. The patients were also invited to discuss aspects of staff-patient interactions and described their initial feelings of shame, relief and hopefulness when admitted to the psychiatric nursing unit. Some felt

coldness from the staff and other patients, while others expressed fears about safety or felt a "tremendous loneliness" (p. 479). Staff were perceived as aloof and unaccessible if patients acted normally, but a patient acting "crazy" would be accepted as a real patient. A number of patients commented on how difficult it was to maintain "a sense of dignity" (p. 480) and normal privacy. This observation had implications for CC since the very act of CC violates the patient's privacy and may impact on his sense of dignity. The patients felt that some staff members were quick to resort to restraints to control behavior, were embarrassed if seen with patients and did not really respect the patient's abilities. Since the patients lived in the United States, the patients had the additional worry about insurance coverage. For example, to obtain insurance coverage, they were required to disclose the nature of their illness and progress. This meant that some patients felt inhibited about revealing their lack of progress if it meant discontinuation of insurance coverage.

Urquhart et al. (1986-1987) studied 291 patients using a self designed patient satisfaction questionnaire and found that patients in individual therapy were more satisfied than those in group therapy, that having a match of gender between the patient and therapist was very important, and that patients were most satisfied with experienced staff regardless of professional orientation. Clarkin, Hurt and Crilly (1987) reviewed 85 studies and found that in 70 percent of them patients would comment positively on the treatment and give reasons that were relational in nature, for example having a match between a patient and a therapist. Piersma (1986-1987) surveyed 1,457 adults and 474 adolescents and found,

like Urquhart et al., that the patients ranked individual therapy as more important than group therapy or medications. Another finding reflecting the study of adolescents was that contact with other patients was very important. These three recent studies show a trend in satisfaction towards relationship building and that patients want individual attention and therapy from experienced staff.

The preceding review of the literature has discussed research and theoretical articles pertaining to CC and other related areas such as territoriality, aggression, alternatives and patients' perceptions of hospitalization. The review suggests that CC may or may not be perceived as therapeutic by patients and nurses and that little is actually known about the essential act of giving and receiving CC. As a result the following research questions were formulated.

Research Questions

1. What is the meaning of CC to patients and nurses?
2. What is the relationship between CC and therapeutic effectiveness of the nurse-patient relationship?
3. What are the expected and appropriate roles of the nurse and the patient during CC?
4. What are the nurses' and patients' perceptions of the purpose and value of CC?

CHAPTER III

HOW IT WAS DONE

Nature of Qualitative Inquiry

Qualitative approaches are modes of systemic inquiry concerned with understanding human beings and the nature of their transactions with themselves and their surroundings. They can be used to expand knowledge about human conduct at many levels of existence: intrapersonal, interpersonal, social, cultural, transcultural and transcendental (Benoliel, 1984). Data from this research consists of richly detailed descriptions of events, persons, situations or behaviors. The researcher's goal is not to seek causes, but to understand and describe the world as experienced by the individual.

The characteristics of qualitative research have been outlined by Leininger (1985, pp. 14-15) and are summarized as follows:

1. The focus is on meaning attributes, attitudes, the totality of experience;
2. The scope is generally broad and holistic;
3. The setting is naturalistic;
4. The orientation is process and phenomena oriented, exploratory, descriptive, inductive;
5. The research goal is the development of understandings and meanings of what one experiences;
6. There is direct involvement and participation with people;
7. The root source of knowledge is human interactions, symbols, and values;

8. The data sought are subjective and objective;

9. The domains of analysis move with the people, context, situation or events;

10. The "tools" for investigation are mainly the researcher, but also open-ended interviews, field notes, direct participation, documents, etc.;

11. The modes of analysis are content, symbolic, structural, and interactional;

12. For the validity indicators, trust is as known to people;

13. The reliability indicators are recurrent themes, patterns and behaviors. This type of research is difficult to replicate due to the unique aspects of context in time and space.

14. The problem areas are the large amounts of qualitative data to analyze.

All of Leininger's criteria are reflected in the present study. For example, nurses and patients in their own setting are asked to describe what it is like to have a good CC experience, bad experience, to identify their feelings and thoughts and so forth. The data are subjective and the participant's descriptions are viewed as their truth; and, the tools are the researcher, field notes and the taped semi-structured interviews.

As in any research project the research question determines the choice of methodology. Qualitative analysis may be particularly appropriate when the research questions focus on the participant's experiences and perceptions and when little is known about the phenomena being studied. Glaser and Strauss, the founders of grounded theory, support the choice of qualitative methods as reflected in the following statement:

> qualitative research is more often than not the end product of research within a substantive area; it is often the most "adequate" and "efficient" method for obtaining the type of information required and for contending with the difficulties of an empirical research situation; and researchers profit from the analyses of their work life (1966, p. 56).

Parse, Coyne and Smith (1985) have differentiated among three qualitative methods: phenomenological, ethnographic and descriptive. Although the data collection method is similar, the methodological structure marks the differences among them. When using phenomenology the data is structured by the participant's (co-researcher) descriptions and the researcher's interpretation of these descriptions, in ethnography the data is structured by the lived experience of the group and in the descriptive method the data is structured by the research questions arising from the conceptual framework. For this study, role theory was used as the conceptual framework and the data will be analyzed in light of the research questions.

Participant Selection

The Director of Nursing of Psychiatry, Unit-based Instructor and Unit Supervisors on Psychiatry were approached about the nature of the research project and each indicated they would support the project by writing letters, being used as participants or directing the researcher to potential participants. The Medical Director of Psychiatry was also approached and supported the project by writing a letter and informing the other psychiatrists that this research project would involve their patients. The Unit-based Instructor informed the nursing staff about the project and invited the researcher to do an Inservice on CC for all staff.

In June, 1987, the researcher conducted the Inservice and answered questions the nursing staff had about the project. For example, they wanted to know how long each interview would take, whether casual staff would be interviewed, if the nurse who cared for the CC patient would both be interviewed simultaneously with the patient, and so forth. The questions were practical and helped clarify the nature of involvement demanded of them.

Nine nurses were approached and eight consented to be participants. The one that refused stated that she did not feel she could contribute any new insights about CC and that she did not like being asked questions that required a quick response. After the interviewing process began, it became obvious to the researcher that the Unit Supervisors had many ideas about CC, so the sample was expanded to include four more participants - three Unit Supervisors and one Unit-based Instructor.

Nine patients were approached to be in the study and each of them agreed to participate. Their names were given to the researcher by the Unit Supervisors, nursing staff and Psychiatrists. All staff were extremely helpful in identifying patients that would be "good" participants, good meaning that the participant had been on CC for a minimum of nine eight-hour shifts or six twelve-hour shifts, was coherent, nonviolent and able to articulate his feelings and thoughts. Of the nine patients, eight were cooperative and articulate. One was incoherent and so the interview data from that session was not used. This patient could not recall being on CC and when prompted said, "Oh yes the time the nurse slept with me in the bed." After that statement, the researcher discussed

with her the need for cigarettes, problems she had obtaining them, and other superficial issues.

The sample size is small because of the nature of qualitative research, each informant being asked to describe in depth his feelings about CC and the meaning attached to the experience (Dunn, 1983; Shavelson & Stern, 1981). Due to the interest in the research topic and the research process, in general, many more participants would have gladly agreed to be interviewed and approached the researcher about being a participant. However, since the researcher was constrained by data overload, money, time, and the limitations of the research questions, there was no need to interview for the sake of interviewing. It was gratifying, though, to experience the tremendous support of all staff in ensuring the access to participants thereby the success of the project was guaranteed.

Interview Method

Each participant was approached at least three times. Initially they were told about the project, what would be expected of them, the type of questions that would be asked and the implications of signing a consent form. In the second meeting, using a semi-structured interviewing method, the researcher asked a certain number of predefined questions (see Appendices B and C) and other questions that arose from the participants' and researcher's dialogue. The sessions lasted from one to two hours, the average being one and a half hours, and were audiotaped. The audiotapes were transcribed, yielding 30 to 60 pages of transcript in each case. The typed transcripts were given back to the participants with a

request for changes or notes on afterthoughts. The most common response of the participants related not to the content of the transcript, but to their use of language. They asked, "Do I really talk like that?" "Look at all these 'ums'." "I had no idea I spoke so disjointedly." Four of the patient-participants did not bother reviewing the transcripts, three of them saying they would be discharged, did not know where they would be living and had no forwarding address, and the fourth noting that everything that needed to be said was said just the way he wanted to say it.

The use of the personal interview allows for asking questions that are deeper than the surface level and require a personal commitment of the participant to reflect on his experience (Fox, 1966). Presence of the researcher, may inhibit "honest" responses and prompt attempts to give socially acceptable answers, which maybe counteracted by taking sufficient time with each participant, varying the type and rate of questions and establishing rapport with the participants. The questions, listed in Appendices B and C, have been termed "guiding questions" and were used for that purpose. The content of the questions was obtained from the review of the literature and personal experience. A panel of four expert psychiatric nurses reviewed the questions for clarity and content.

Most of the interviews took place in an office on the unit. Six of the nurse participants chose to be interviewed in the researcher's office away from the unit. Four used their own time and four were given release time. The primary nurse and/or Unit Supervisor were notified when and where the patients were interviewed. Bodgan and Biklin (1983) advise researchers to gather data in the actual setting, to facilitate the

researchers' understanding of the context of the descriptions. This proved to be true and facilitated the escorting of the patient back to their own rooms. As well, the researcher was able to report to the primary nurse in general terms what had transpired between the patient and researchers. No actual content of the interviews were released to staff, although nurses frequently asked what the patients had said. In hindsight, interviewing the patient post CC was apparently protective to both the patient and the researcher. Sensitive data about the nursing care did not have to be revealed to the nursing staff.

The interviews took place between August, 1987 and February, 1988. The best time for the interviews with the patients was in the late afternoon or early evening; the nurses were interviewed mainly in the early afternoon. The time period that was most suitable for interviewing was the Christmas holiday, since patients and staff had few structured activities during that time and were freer to give two hours to someone else.

Reliability and Validity

It is difficult to replicate qualitative studies because the researcher acts as the "research instrument" and gathers data in an ever-changing natural setting (LeCompte & Goertz, 1982). To increase reliability, detailed descriptive and reflective field notes must be kept. The methods used to select and interview participants as well as the data analysis must be fully described in the research report.

Reliability is affected by the researcher's status and role. Due to the researcher's experience in psychiatric nursing, she had the

necessary skills to interview patients and staff. She had to be explicit about the purpose of the research project and needed to articulate any biases, which was accomplished through the Inservice, meetings with the Unit Supervisors and the field notes. To increase reliability, the participants were asked to verify the data after the tapes of the interview had been transcribed and again those that are available will be asked after the dissertation has been written. A peer, not associated with psychiatric nursing, was asked to review the data and her findings are reported in Appendix H. Use of the peer is helpful in identifying biases, strengths and weaknesses (LeCompte & Goertz, 1982).

Validity should be high in this study because the researcher did the interviews and what the participants gave for information was seen and accepted as their reality (Bruyn, 1966). Other considerations when examining validity would be language requirements, degree of intimacy, consensus, time, place and social circumstances (Homans, 1980). These considerations were discussed with the Unit Supervisors prior to interviewing patients, and addressed in the field notes.

Bias

The researcher has to be vigilant to the effects of bias since she had experience working on psychiatric nursing units. It was important for her to be aware of personal values and prejudgments so these could be put aside while interviewing. Also, the participants were not led on and induced to think certain answers were right or wrong; instead, they were encouraged to give honest feelings and impressions about CC. When interviewing patients, she presented herself as a researcher and not as

a nurse so the patients were not confused about the nature of the relationship. It also was assumed they felt safer in disclosing sensitive data to someone removed from the nursing unit.

Data Analysis - Qualitative

After the completion of the first interview, the audiotapes from that interview were transcribed and xeroxed. One copy of the transcription was given to the available participants to review and the researcher reviewed one copy and checked its accuracy against the original audiotape. The review of the transcription consisted of asking the following questions: What does the participant mean? What was the context for the response(s)? How well were the planned questions answered? The unplanned questions? What data did the researcher miss?

After all the questions were answered and the final transcript was viewed as complete, the transcripts were placed in three piles: patients, nurses, administrators. Initially the researcher did this to reduce information overload, but latterly all the data was grouped into seven categories and each category maintained a patient or nurse perspective. The original transcripts were read and many categories of content identified. As listed, these were: gender, washroom, eating, privacy, environment, other patients, personality factors, closeness, caring, guarding, trust, being off CC, family and visitors, medications, shifts, sleeping, space, feeling, bad experience, good experience, dressing, making decisions, alternatives, attitudes, bridges in the hospital, negative consequences, kind of patient, kind of nurse, reaction to CC, float versus regular staff, repeat of CC, control, CC in other

institutions, and CC on the weekend versus the week day. Since this was still unworkable, the categories were collapsed into seven areas: nursing, administration, description, environment, alternatives, feelings and others. After these areas were established in the researcher's mind and defined on 5" x 7" file cards, the content fitting each of the seven areas on the transcripts was identified. This was facilitated through the use of The Ethnograph (1985), a computer program designed to manage and analyze qualitative data. Each of the transcripts was typed using Multimate, a word processing package that is compatible with Ethnograph. The transcripts included the source of the information and each of the lines, composed of no more than 39 characters, was numbered. These numbered, short-lined transcripts were printed and then code mapped. This meant that the researcher bracketed any content that pertained to one of the seven categories (codes) previously identified. A segment of the transcript could contain more than one reference to a specific area and so the researcher was able to use multiple codes, or in Ethnograph language, the segments could be "nested" to a maximum of seven levels. To illustrate, when a patient said that he felt frustrated being confined to the unit and wanted someone to change the CC order to being checked every ten minutes, this was coded simultaneously as administration, feelings and alternatives. After the data was coded, a research assistant entered the code into the computer. The Ethnograph sorted through the codes and grouped the codes into seven categories, retaining the source of the code on the transcript with certain symbols. The effectiveness of the Ethnograph, as compared to a straight card hand sort, is the way data can be organized into single or multiple categories and secondly,

retrieval of data takes minutes versus hours. The data for each of the seven codes were placed into seven binders. The researcher then went through each binder and reduced paragraphs to single statements which were written on the empty left hand side of the coded transcript. When this was completed the statements were reduced to words or phrases and written on 5" x 7" filing cards. The filing cards were arranged and rearranged in an attempt to make sense of the themes that had emerged deductively from the larger categories and to see how the data answered the research questions. There were only four research questions and 700 pages of coded transcripts, so at times it was difficult to juxtapose questions and answers.

Data Analysis - Quantitative

As part of the significance of the study, it seemed reasonable to prove that CC occurred on these three units and that its frequency of use merited counting. The time period for counting consisted of July 1, 1986 to July 1, 1988. Since statistics on the frequency of CC were not kept, a research assistant combed through the daily nurse assignment sheet to ascertain who was on CC, who cared for them, and how long they were on CC. This relatively simple task turned into a work project that consumed 240 hours for the following reasons: the daily assignment sheet was handwritten and contained a number of spelling errors; it covered three shifts and therefore a great deal of data was compressed into small spaces; the style of recording data on the assignment sheet varied with the nurse in charge; assignments sheets were transported off the unit in small batches (covered in a box or envelope) to maintain confidentiality;

and assignment sheets for each week of the time period were not available and so a number of trips had to be made to the units to find the missing sheets. The actual number of weeks analyzed equals 242 because one of the units had a change of management and, with the change, the assignment sheets were lost. The data that was gathered will be discussed in Chapter IV, "What was said and what was found."

Nature of the Population and Setting

The study was conducted in a 50 bed active treatment adult inpatient service of a 843 bed tertiary care hospital located in a metropolitan area. Patients are referred to this service from a large northern catchment area as well as from the city and surrounding suburban municipalities.

Patients admitted to the inpatient unit suffer from acute psychiatric disorders or exacerbation of chronic illness. Their ages range from 14 to 85 years of age and average length of stay is three weeks. All patients are admitted on a voluntary basis. The nurses employed on the adult units are Registered Nurses or Registered Psychiatric Nurses. Other employees are assigned to the units from the psychiatric and general relief pools for vacation and illness replacements or to meet workload demands.

The actual sample consisted of eight nurses, six female and two males. Of those eight nurses, two held a Registered Psychiatric Nurse's diploma, three a Registered Nurse's diploma and three a Baccalaureate in Nursing Degree. The years of psychiatric nursing experience varied from two to fifteen. Of the Unit Supervisors, one was a male and two were

female, and all had a Baccalaureate in Nursing Degree. The female Unit-based Instructor who also served as a participant held a Registered Nurse's diploma.

The patient sample is shown in Table 1. The primary diagnosis was obtained from the doctor's progress notes and intake history since the admitting diagnosis usually was broadly termed as depression or psychosis. The data from the female patient who had Organic Brain Syndrome was not used in the analysis.

Ethical Considerations

A consent was signed by each of the participants (Appendices D and E). The proposal received ethical approval from the Faculty of Education, University of Alberta, according to the University Policy Related to Ethics in Human Research as approved by General Faculties Council on January 28, 1985. In the agency, approval for the research project was received from the Nursing Review Committee and, since patients were involved, the Special Services and Research Committee. To protect the identity of participants, all have been given fictitious names in the dissertation.

There are three ethical issues that need to be addressed when doing research on patients: right to privacy, informed consent and confidentiality (Sudman & Bradburn, 1982). For psychiatric patients, there is also a concern about competency (Rose, 1986) and coercion. Due to these ethical issues, patients were approached to participate after they have been on CC; interviews with all the patients were conducted in an office adjacent to the psychiatric unit; and, permission to interview

Table 1

Patient Sample

Patient	Primary Diagnosis
Female	Anorexia
Female	Depression
Female	Schizophrenia
Female	Depression
Male	Alcoholism
Female	Bulimia
Male	Depression
Female	Manic Depression
Female	Organic Brain Syndrome

the patient was obtained from the primary nurse or the Unit Supervisor prior to approaching the patient for permission. The researcher's preparation in psychiatric nursing assisted her in being sensitive to patient's emotional states and in assessing the patient's reactions to being approached and/or interviewed. Nursing staff were aware that certain patients were being interviewed, but were not informed of the findings. The results of the research project will be made available to the staff after the patients have been discharged from the hospital through copies of the written report and an Inservice.

CHAPTER IV

WHAT WAS SAID AND WHAT WAS FOUND

This section includes the themes identified by the patients, nurses and Unit Supervisors, analysis of the quantitative data and reference to the value of having an external reviewer. The themes are grouped under headings of nursing, administration, feelings, others, environment and alternatives. The only area, generated by the Ethnograph program that does not have a separate section is "descriptions." These have been interspersed throughout Chapter IV and V to highlight and illustrate certain themes. Summaries, as a means of further reducing the data, are used after each theme or a small grouping of themes.

Quantitative Results

As part of the rationale for studying CC it seemed prudent to find out how many patients were actually on constant care. To determine how this should be accomplished the Unit Supervisors and personnel from the Director of Psychiatric Nursing's office both recommended that the researcher study the daily patient assignment sheet (Appendix F) since no other mechanism was in place to identify which patient was on CC and for what length of time. Records were being kept as to how many extra nurses a particular unit required but it could not be assumed the extra staff necessarily did CC. A research assistant transcribed the name of the CC patient and the nurses who cared for the patient on to a research sheet (Appendix G). After this was completed the researcher was able to ascertain how long patients were on CC and how many different nurses they had. This data is summarized in Tables 2 and 3.

Table 2

Number of Patients and Nurses on CC
Units A and B

	Unit A		Unit B	
	July 1986 July 1987	July 1987 July 1988	July 1986 July 1987	July 1987 July 1988
Number of patients on CC	68	82	97	102
Total number of CC shifts	1,204	1,371	1,368	1,557
Average number of CC shifts per patient	18	17	14	15
Average number of different nurses per CC patients	14	15	17	13
Lowest CC shift number per patient	1	1	1	1
Highest CC shift number per patient	210	147	143	106
Lowest number of different nurses per patient	1	1	1	1
Highest number of different nurses per patient	94	100	93	68

Table 3

Number of Patients and Nurses on CC
Unit C

	January 1, 1987 August 1, 1987	April 20, 1988 July 1, 1988
Number of patients on CC	59	18
Total number of CC shifts	1,145	176
Average number of CC shifts per patient	19	10
Average number of different nurses per CC patients	16	9
Lowest CC shift number per patient	1	1
Highest CC shift number per patient	141	16
Lowest number of different nurses per patient	1	1
Highest number of different nurses per patient	80	34

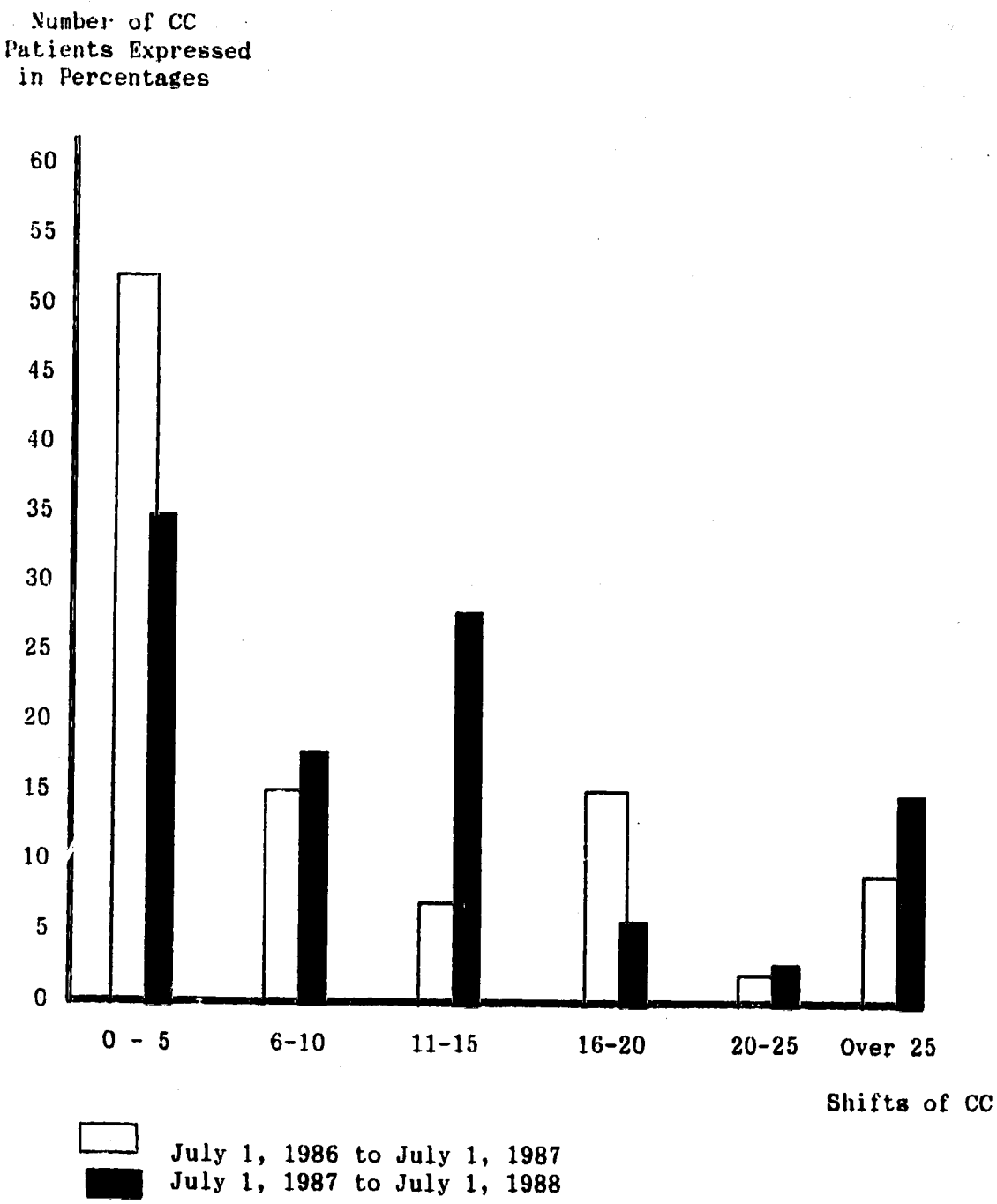
Since Unit A and B's Unit Supervisors were able to provide data for a two year period the data can be compared; unfortunately Unit C's Unit Supervisor could only provide data for a 37 week period and so the data merely describes CC frequencies on that unit. For the entire period, July 1, 1986 to July 1, 1988 there were 426 patients on CC. The highest number of CC shifts (8 hour) for a patient was 210 which translates into 70 days or 10 weeks. The highest number of different nurses per CC patient was 100. Such a high number of contacts for the patient should increase the patient's stress from over stimulation.

The average number of nurses per patient ranged from 13 to 17 which indicates a departmental philosophy of not keeping the same nurse with the same patient. Unit A had fewer CC patients than Unit B which was probably related to the fact that psychiatrists order CC and since both units had different psychiatrists - one group ordered less than the other group. The psychiatrists are also beginning to specialize in areas such as eating disorders, psychogeriatrics and psychotic disorders which would mean that certain psychiatrists would be more likely to order CC for the type of patient they admitted.

While working with the patient daily assignment sheet the researcher became aware of a number of patterns. It was noted that it was possible to have four nurses caring for one patient over three shifts, since a few worked four hour shifts. Most of the patients began on a CC rotation and were on CC for consecutive shifts but a few were on CC only at night or only on days and evenings and then off at night. A few patients were on CC, came off, and then were on CC again. When coding data on this type of patient both episodes were counted as one CC experience but the number

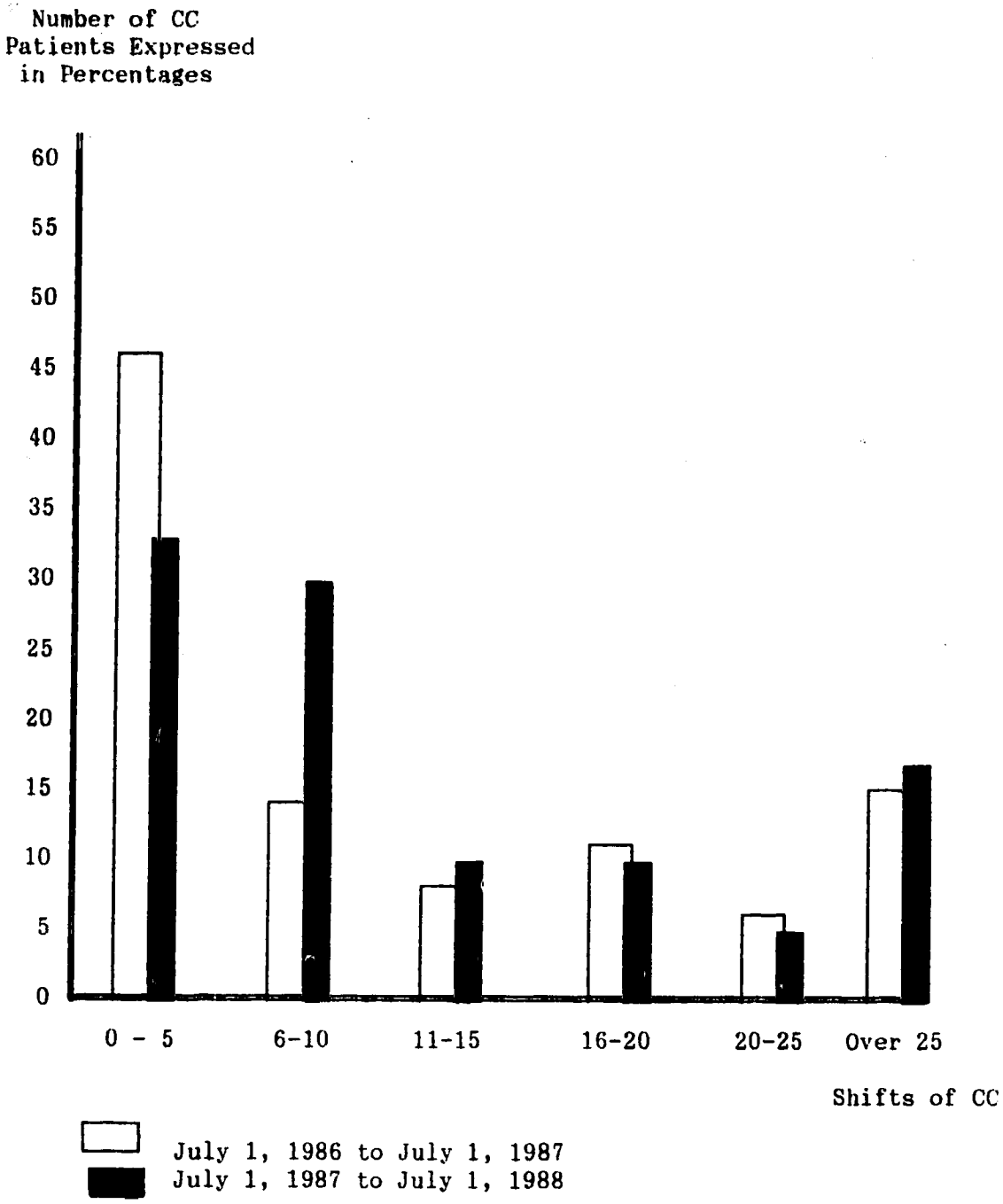
of different nurses were counted using all the data. As well, a few patients had two nurses assigned to them and four patients had security guards plus nurses. The security guards were not counted but each nurse was counted which meant a CC patient could have six nurses over 24 hours. Lastly, it was observed that a casual nurse was on CC on Unit A, the next day she did CC on Unit B and the next on Unit C. There seemed to be no attempt to keep the same nurse with the same patient.

To ascertain the pattern of frequency of CC related to number of shifts, the number of patients per shift were counted from 1 to 25 and over 25. These numbers were then converted to percentages to demonstrate what percent of patients had CC for only 0 to 5 shifts, 6 to 10 shifts and so forth. The data for the three units are presented in Graphs 1, 2 and 3 respectively. Graph 1 shows that over half of the patients on Unit A were only on CC for 0 to 5 shifts from July 1, 1986 to July 1, 1987, but the length of time on CC increased the following year where half of the patients were on CC for 11 to 15 shifts. The same trend occurred on Unit B except the number of shifts increased only from 6 to 10. Each of the three units had 15 percent or greater CC shifts for the over 25 shifts category which meant that a fair number of patients did not immediately respond to the therapeutic effects of hospitalization. It would also indicate that a high total of CC hours per unit over a one year period would be influenced by a small number of patients. For example, there were 1,557 shifts of CC for July 1, 1987 to July 1, 1988 on Unit B, which meant that 17 patients inflated this number by having CC over 25 shifts; had these patients not been on the unit the CC shifts would have dropped from 1,557 to 727.



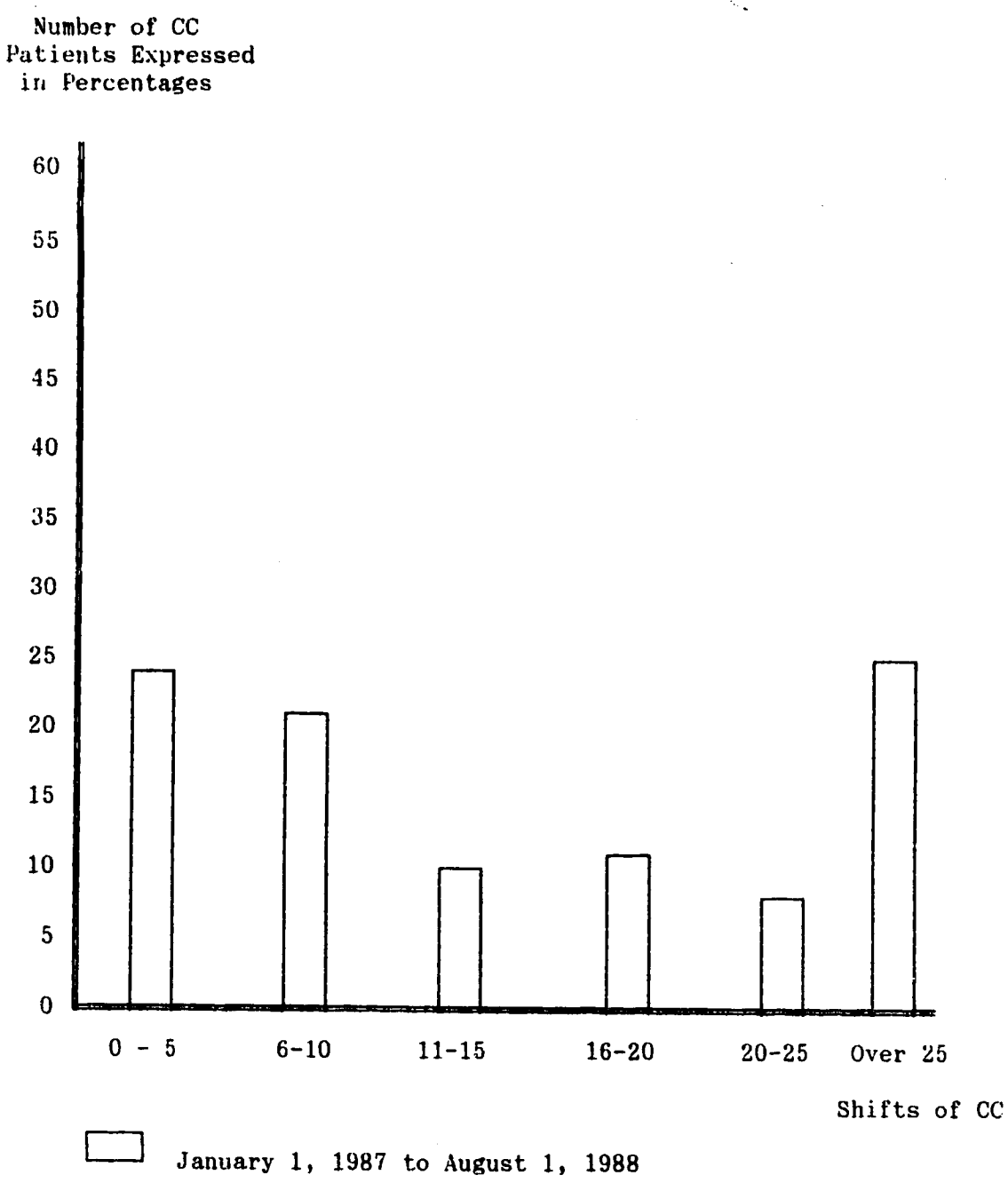
Graph 1

Relationship Between the Percentage of Patients on CC and the Frequency of Shifts on CC for Unit A



Graph 2

Relationship Between the Percentage of Patients on CC and the Frequency of Shifts on CC for Unit B



Graph 3

Relationship Between the Percentage of Patients on CC and the Frequency of Shifts on CC for Unit C

Table 4 depicts the number of shifts and different nurses for the patients in the sample. The shifts ranged from 9 to 147 and the number of different nurses from 8 to 100. The range was unanticipated but in retrospect was very helpful for gathering data from inexperienced to experienced CC patients.

Summary Statement

The data on the daily patient assignment sheet allowed the researcher to determine the frequency of CC over a given time period and the number of nurses providing CC. It became apparent that half of the patients were on CC for 15 shifts or less but that a large number of patients were on CC for over 25 shifts. This meant that the total number of CC shifts per nursing unit over a one year period were greatly increased by a few CC patients. The average number of nurses per patient was in the midteens which demonstrates a philosophy of rotating nurses through CC experiences. One patient had 100 different nurses which raises questions about management of nurse-patient assignments. The value of collecting this data lies in the proof that CC is a common experience; raises questions about the practise of having a patient on CC for 10 weeks and having the patient exposed to 100 different nurses; and, as the interview data will attest, confirms the patient's experience of having little continuity in nursing care.

Nursing

Patients

The patients were extremely articulate about the nursing care they received. They were able to list over 50 specific nursing actions that

Table 4

Number of Shifts and Different Nurses for Patients in the Sample

	Total Shifts of CC	Number of Different Nurses
Patient A	147	100
Patient B	10	11
Patient C	35	26
Patient D	135	70
Patient E	17	17
Patient F	43	27
Patient G	9	8
Patient H	10	10

they perceived to be helpful. Advantages of being on CC were also identified but were stated in general terms such as felt safe, increased my confidence and had extra care. A few disadvantages to CC were offered as well and referred to specific negative experiences with certain nurses. The patients also had personal preferences for certain types of nurses.

To illustrate how perceptive the patients were about nursing care, the specific actions that they found to be helpful will be listed in order, under the four themes of providing structure, communicating respect, teaching specific skills and caring.

Nurses provided structure by:

a) making the patient do things like playing cards;

b) giving the patient a homework assignment like thinking of five positive events that have happened in the patient's past;

c) insisting that the patient think of one goal per shift to enhance positive feelings. This goal also had to be written;

d) providing diversional activity which in turn helped the patient to concentrate, took away negative thoughts and challenged the patient to think about themselves;

e) insisting that the patient make plans for the next shift; and

f) involving the patients in what they were doing such as telling them about their knitting.

Nurse communicated respect by:

a) asking the patient what he was going to do that shift to make himself feel better;

b) asking the patient her opinions, asking good questions and inviting the patient to take part in making decisions;

c) making the patient realize that there were things that she did like to do and stimulated her to reflect on her abilities;

d) differentiating between what patient could and could not handle;

e) remembering the patient's name;

f) giving eye contact;

g) letting the patient know when the nurse was going to go for a break and at what time she would return;

h) keeping the patient on the subject;

i) motivating the patient to work harder;

j) helping the patient understand that little steps precede larger ones;

k) making the patient do things by herself;

l) communicating an attitude that she was "for the patient";

m) letting her go to the bathroom on her own while leaving the door open 3 inches;

n) making the patient feel comfortable while eating;

o) offering hope;

p) not giving advice; and

q) stopping the patient from dwelling on suicide.

Nurse taught specific skills, such as:

a) stress management through the use of self talk, removing yourself from a negative situation and providing a relaxation tape to listen to;

b) problem solving skills by asking "now what would you do?"

c) reframing by looking at events from other than patient's perspective;

d) how to find fun and enjoyment in life again;

e) health teaching regarding relationships, medications and illness;

f) communication skills by working on specific skills such as the use of "I statements";

g) being confident by role modelling these behaviors;

h) how to decrease hallucinations and to increase awareness of the present physical environment;

i) how to regain control over thoughts and feelings;

j) how to work collaboratively with family members; and

k) how to pace conversations and interactions.

Nurse communicated caring by:

a) her tone of voice;

b) sharing with the patient. Sharing an apple, bringing in reading material and even old clothing;

c) disclosing to the patient why she liked nursing, what she had done on her weekend or what her plans were when she ended the shift;

d) her attitude. Communicated to the patient that she was proud of the patient, eager to help, sincere, not embarrassed by having to be with a psychiatric patient, offered total acceptance, showed no biases and made the patient feel he was a priority;

e) nonverbal communication such as sitting on the bed, touching the patient and rubbing the patient's neck;

f) comforting the patient, asking if the patient was O.K. and covering her up at night;

g) giving the patient immediate feedback;

h) being sensitive to the patient's mood and need for superficial conversation;

i) getting to know the patient and spending time reading the chart;

j) tolerating the patient's need to do the same thing over and over again like getting a drink from the fountain;

k) dropping in to check on the patient after CC was over;

l) doing physical things for the patient like changing her bed, washing her hair and assisting her physically when her legs were shaky;

m) being nice to the room mate and encouraging the room mate to talk and do things with the CC patient;

n) mobilizing the patient and getting her to comb her hair, brush her teeth or get dressed;

o) making the patient feel better by making her look better;

p) treating the patient like a friend and developing mutual trust;

q) anticipating what the patient intended to do;

r) demonstrating a commitment to CC nursing. As one patient stated, "the nurse made it seem that she had thought about CC and saw the reason for it."

s) withholding negative feelings that she must have felt toward the patient;

t) providing a safe environment by positioning herself between the patient and the door or the railing;

u) being there and radiating positive feelings;

v) doing a total assessment which not only included the patient but family members as well;

w) giving the patient "extras", meaning extra care, attention and time;

x) using her personality. The patients classified the helpful nurses in terms of their personality types. This included the quiet, calm, kind, involved, agreeable, comfortable and understanding type;

y) forgiving the patient especially since the patient had a hard enough time forgiving himself;

z) being versatile which means talking about any subject; and

aa) giving the patient the chance to talk first.

The specific helpful nursing actions recalled by the patients demonstrated that very ill patients who may appear confused and disordered still retain abilities to assess other's behaviors. They recognized that they felt scattered and disorganized and therefore wanted a nurse who was "together". The comments about the nurse's personality were interesting since the patients did not discriminate between the personality of the nurse and her skills. Her presence and what she was like as a person were

very important whereas her skills were assumed to be "just there" since she was labelled a nurse.

The negative aspects of CC included references to the bathroom, lack of privacy, lack of continuity and specific behaviors of a few nurses. Being on CC while in the bathroom irritated most of the patients because they believed that the assumption was made by the nurse that the patients would hurt themselves. Staff were inconsistent about actually being in the bathroom and the patients felt tense not knowing what staff members were going to do. One patient would go to the bathroom only on shifts where she was assured the nurse would not be with her. The lack of privacy was expressed in terms of being stared at, having a CC nurse stay when talking with visitors, having the nurse watch you eat and feeling uncomfortable having some one awake in the room when you are trying to sleep. The problem with the lack of continuity was described in terms of irritation at replacement staff who asked too many questions, being requested to explain their illness to "new" nurses and feeling anxious as to what the new nurse would be like. A few nurses acted in a manner that angered the patient. One nurse "dragged the patient around" and made the patient sit by the telephone so she could make personal calls. The same nurse was also moody and the effect of this emotion is described by Sally:

> . . . she's really moody. She gave the janitor hell, gave the lady in the--downstairs in the store place hell. She's not right for a psych ward. Just keep her away from here. Every time I run into her, we just look away. But I remember telling my girlfriend that I felt so bad about it.

Colleen, who also had this nurse, agreed with Sally's assessment. When this nurse did CC with Colleen, "she read the paper all day." As a result

of this behavior Colleen had to initiate all nursing activities. When the evening nurse arrived Colleen was so relieved she became "manic with joy." Another patient had a nurse who "never spoke a word for the whole eight hours." His response to this was quite marked as shown in the following quote:

> I got more and more and more depressed. I just lay on my bed and closed my eyes for the whole eight hours. Didn't want to have anything to do with them. Didn't know what else to do.
>
> It was worse than having nobody there. I lay down, hid my face. I didn't even want to sit up and read because I had to look at her. And maybe I'd have to think of something to say to her, and the effort just wasn't worth it. So any thoughts I had of suicide were very prevalent that day.

Marcia had a negative experience with a nurse on nights. She described his behavior as threatening and self-centered. An example of this behavior was the following repeated statement, "If you don't do this I'll get in trouble." The patients also observed that the nonverbal behavior of a few nurses communicated that CC was bothersome, boring, routine and one patient felt the nurse thought he was an "idiot and stupid." Sally noted that CC was particularly hard on the nurse and the patient when it was not really required. This meant that the patient had to entertain the nurse and the nurse had to feign interest in an old, over-discussed problem.

The patients had strong personal preferences for certain nurses and even hatred for ones they did not like. Sally wanted a nurse she could express her feeling to, one who really understood her and who respected her privacy by charting while Sally ate. However if Sally did not have this type of nurse she would "punish the nurse by acting out." Marcia

preferred a "motherly type" nurse because she thought that only a mother could put up with her "miserable and owly" behavior. Lucy best described her personal preferences as illustrated in the following quote:

> . . . it depends who actually happens to be on constant with you. Some of them you really despise, and others you sit there and talk with and have a great time. You don't pick, so depending on who you happen to get really makes a difference as to whether it's shut up and leave me alone or, you know, okay, let's talk or something.
>
> I grew to like certain nurses, and hate certain nurses . . . some of them, like, they're kinder, they kind of understand, they know you from before so they understand the way you're reacting. And they're quieter and calmer. Maybe because I know them and I like them, I try and behave more than when it's somebody sitting there that I actually don't like 'cause then it's like, I really don't want you around, get away from you.

Like Sally, Lucy "punished" nurses she did not like by misbehaving. This behavior has implications for how CC care assignments are made.

Summary Statement

The patients were very articulate in identifying helpful nursing actions. These actions were grouped under the themes of: nurse provided structure, communicated respect, taught specific skills and demonstrated caring. The negative aspects of CC included references to being watched in the bathroom, not having sufficient privacy, and lack of continuity among staff. A few nurses angered the patient by being moody, making threats, withdrawing from the patient and communicating nonverbally that CC was tedious. The patients had marked personal preferences for some nurses and two patients punished their nurse by acting out. The patients were extremely alert to the nurses' behaviors even though the patients'

behaviors at the time of CC usually were usually confused and disorganized.

Nurses

The nurses had a number of observations about the meaning and nature of CC and substantiated their observations with directives detailing the establishment of therapeutic relationships, preparing one's self for CC, creating a sense of privacy and managing the violent or angry patient. Other themes that were identified included coping, interacting with visitors, supervising the patient during meals and in the bathroom, personal preferences and negative experiences during CC.

Meaning and Nature of CC

> . . . one could be doing constant care on oneself, or one could distract oneself. Either distracting by intellectualizing and going to chart, reading a bunch of junk, or reading a humorous novel, or doing some other tasks--anything than face oneself.

In this description Terry sees CC as an experience for the patient and the nurse. The nurse may be giving CC but is also receiving CC and so she has the option of being part of it or trying to distract herself from it. It is also a time for self growth by providing an opportunity for confrontation with a nurse's own values. Terry noted, "he could deal constructively with his frustration as opposed to whining and simply being negative." Megan supported this by an observation that there are patients "that touch you in certain ways" and you are helpless but to respond to them. No matter what you are feeling like you have to let yourself be involved. Anne described CC "like a forcement of two bodies occupying the

same space." She concluded that if the patient had a personality disorder then giving CC was more harmful than good because it reinforced behaviors that should be ignored. As well, if the patient was very paranoid, the constant presence of the nurse often agitated such a patient. Lorna agreed with Anne and cited cases where she knew her presence was making the patient worse because "they just couldn't stand having somebody around them all the time."

The passage, meaning and use of time plays a part of CC. Anne stated that "the time you are on CC is not your time. You are not there to benefit yourself but the patient." Lorna noted that the time on CC goes fastest if you are involved in an activity with the patient. To do an activity you have to get to know the patient, find out their likes and dislikes and believe that you can find something they like. Terry noted, "my own time spent in CC has a qualitative valuelessness about it." He explained that he understood he would not be able to effect any catharsis and necessary changes in his patient's lives, that the patients needed a certain quality of care that could not be given in a hospitalized setting. This meant that it did not matter how much time was spent on CC because the act of CC was not sufficient in helping the patient. Garth in a way supported this belief when he stated that the nursing role during CC is somewhat limited to biological care and that counselling and health teaching happen later when things are more orderly. Megan valued the extra time CC gave her and stated it was a "bonus" when caring for certain patients. It allowed her to get to know family members, develop rapport with the patient, do genealogical assessments, keep the bedside and room tidy and have some uninterrupted "heart-to-hearts."

What happens between a nurse and patient in a CC situation is part of a dynamic relationship that is always changing. The context is unique and events that occur need to be viewed in a holistic manner. For example, Garth noted that when he hears reports about a CC patient that has done something unacceptable and a nurse who has not managed the patient's behavior, he focuses on the thought that the nurse was doing the best she could at that time. He was not there and influenced by covert and overt factors and therefore can not judge the nurse. His comments are illustrated by Anne's descriptions of angry feelings. She felt she had been assaulted by a patient as described in the following quote:

> I felt some anger towards the patient. I didn't say anything to the patient. I just said that I didn't appreciate being pushed aside, and I felt that that was wrong for her to do that. There was anger that I couldn't act out at that time, I had to be in control, you can't vent your anger on a patient. They're the ones you are helping.

Her feelings of anger had to be suppressed and she observed that the patient was more important than her feelings.

CC is a time for focusing on the patient when the nurse is not distracted by other duties or other people. Since the patient is very ill, Terry believes that the nurse should be delicate with them. As well, psychiatric patients have a certain vulnerability and can be manipulated to do things they normally would not agree to. This belief is reflected in the following quote:

> . . . psych patients in general have a certain vulnerability about them that leaves them open to being bossed around, or given partial information that is supposed to satisfy them, or just put off by "your doctor will explain that to you tomorrow."

Terry understood at some level that his power was enhanced merely by being with some one who was fragile.

The nurses offered a number of suggestions about the nature of CC which have been written as directives. They felt strongly as to the "right ways" of nursing CC patients and so their statements have been written as actions other nurses could model. The directives are organized in four categories: building a therapeutic relationship, preparing for CC, creating a sense of privacy and managing the violent and angry patient.

Building a therapeutic relationship:

a) A nurse increases rapport with the patient by giving them medication;

b) If a patient does not like CC, you do not converse with them but instead sit and read and let them initiate conversations;

c) The hardest part of CC is repetition, the same words or actions, can really get to you;

d) If the patient requires an explanation as to why he is on CC, the nurse needs to be as tactful but honest about it as possible. For example the nurse may say, "I'm concerned you might hurt yourself, or concerned that you are unpredictable;"

e) If a patient asks why he is getting all this medication, the response is something like, "we're adjusting your medication right now and that takes awhile. The ultimate intent is to help you think more clearly and to get over this;"

f) When conversing start talking about light, superficial topics, then disclose something about yourself, after, find some mutual interests and then discuss what is really important to them;

g) Make an effort to develop some sense of trust but do not trust too easily if the patient is very psychotic, suicidal or if you feel scared. With a suicidal patient you have to understand that they may be all right one minute but the next minute their emotions may overwhelm them, and you can not trust them to fight off their black moods;

h) The nurse has to control her own feelings and be careful not to panic as a result of what the patient is feeling;

i) After a nurse is experienced in nursing depressed patients she can anticipate how other depressed patients feel and can say "I have seen other people go through this, it is a sign and symptom of this illness and I know you will get better;"

j) The nurse needs to do plain "old nurturing" with depressed patients. Touch and reassure them by "normalizing" things. Since they are frightened they need to be supported and understood. Say to them, "this is not normal, what is normal like for you?" Draw them out because you want to get them outside of themselves. The worse someone feels, the more inside they are in a physical way. You have to do this over and over again because the illness keeps sucking them back. There is an external and internal world and the more internal you are the lousier you feel. The nurse needs to say to the patient, "look at me, then look at the wall." Then tell them why they have to do this. None of this works for a long period of time but it gets them through and keeps them alive;

k) The nurse can feel with the patient. For example, when they are talking about feeling slowed down the nurse too has experienced this feeling to a degree and just has to image what it would be like to have that feeling for a long time;

l) It is important to help the patient focus on other things than themselves. This can be done by bringing the newspaper to them, asking them if they have any calls to make or asking them if they would like to watch television;

m) If the CC patient is not in a semiprivate room, the patient's room mate can play a significant part in the recovery process. They have to put up with the behaviors of the CC patient and understand why this patient is getting more attention than they are. By acknowledging them and explaining what is happening they will be more willing to support the CC patient;

n) Part of forming a therapeutic relationship is getting to know the patient, making him feel comfortable and safe. Communicate to him that it takes time but things will get better as he is helped. Tell him there is hope. Tell them, "I know how badly you feel but I believe you will get better." At the time the patient does not believe you but they have said after they are off CC that the statement gave them reassurance;

o) Part of being helpful means believing and accepting yourself. Some patients present with behaviors that you can not figure out but as you get more experienced you develop your own techniques and sometimes you do things and you do not know

whether they are right or wrong, but you do them in good faith;

p) It is irritating when a patient is set back in their recovery. The nurse needs to accept that will happen and let it be;

q) There are times that a patient wants a cup of tea or a cigarette which means leaving the unit. Your gut feeling tells you that you can not trust this patient even though on the surface everything seems all right. Do not deny them the privilege of leaving the unit but ask another nurse to come along;

r) The nurse needs to vary her approach with each patient. For example if a patient is on CC when initially admitted you have to be "more cautious while being laid back" compared to a patient who has been in the hospital for a week prior to being placed on CC;

s) When nursing a paranoid patient it is important not to be threatening. Do not ask too many questions, keep your distance and appear calm. Talk in a calm, soft voice and do not make any sudden movements. Carefully assess your own behavior so you do not appear suspicious. Explain to him what you are doing and why you are doing it - make it seem CC is for his benefit. He has to know you are not trying to hurt him or doing anything behind his back.

Preparing for CC:

a) Prepare for CC by reading the chart. Read the notes on the last 24 hours and the admission history. By reading the chart the patient is not asked the same questions again and again;

b) When giving report to the next staff member who will be caring for the CC patient tell them the diagnosis. You could also give them a prediction of what the patient will behave like based on how your shift went and the time of the last medication. Since the nursing care plan is on the chart they should be directed to it and asked to make any changes as needed. Assess how well they know the patient and give them only as much history as is pertinent because they can study the chart later on;

c) The CC patient is very sick so the nurse needs to prepare herself for the experience by telling herself to be alert, thorough in her assessments and that the patient can not be trusted. If the nurse knows the patient there is an "understanding that is transmitted" and that understanding sets the tone for how the shift will go;

Creating a sense of privacy:

a) When sitting with a patient, the nurse needs to make an effort to be unobstructive and inconspicuous;

b) Nurses may need to be more aware of privacy if the patient really cares about it;

c) Male nurses need to be sensitive to male patient's nakedness and not just female patient's nakedness;

d) When a patient is dressing it is important not to stand and stare. Help them pick out the articles they need and perhaps make some suggestions to start dressing. Draw the curtain a "wee bit" to give them a sense of privacy but continue to watch them;

e) A nurse creates a sense of privacy by avoiding eye contact at times when a patient would normally be alone. For example if you watch them to closely while they wash themselves they will not wash as well;

f) Privacy granted is a matter of degrees. For suicidal patients a nurse may feel too ill at ease to allow for privacy, but if the patient is an elopement risk then privacy can be fostered. The nurse needs to make a judgement call and consider her feelings, diagnosis and the patient's behavior;

g) Whether or not a nurse charts in front of a patient depends on the nurse's judgement. If a patient asks what the nurse is charting she should tell them;

h) While a patient is dressing use the time to covertly inspect the patient's skin rather than having them expose themselves for a routine physical inspection. The visual assessment may also reveal signs of self mutilation. If a patient appears uncomfortable, say "I am sorry but I have to be with you to make sure you are safe."

Managing the violent or angry patient:

a) If confronted with an angry patient, try to show no fear because the patient can read it in your eyes and face. Try to be cautious by keeping a safe distance from the patient. Position yourself between the patient and the door, and if there is a window, ensure that other staff can see you. Check to make sure you know where the call lights and alarms are. Concerning clothing (even footwear), wear nothing that can be grabbed. Be sure to know the actions and effects of medications and give the patient medication when you think they need it and not after they act out;

b) Prepare yourself mentally by asking, "what can I do if . . .?" No patient is violent for eight hours, they can not stay at that peak. The nurse needs to watch them like a hawk for any subtle changes that indicates the patient is about to explode. Stand away from them to give you time to react to their outburst. Try to talk calmly and softly, think calm thoughts, and tell yourself to relax. Move slowly and try to keep "the volume turned down" in everything you do;

c) Patients will displace their anger on to you, swear at you and tell you your not a good nurse. They will put you down when you know you do not warrant this behavior. Ask yourself, "where is this anger coming from?" Put yourself in a cognitively different mind set by saying, "it is not me that is causing this anger, something else, but they are venting it on me." At first the patient's angry projection will surprise you and when you are on CC you can not just get up and leave the room. You have to sit there, listen to it and deal with it. The nurse has to think on her feet and if she can not do that she has to buy time but she has to stay there, buying time;

d) If the patient is resting the nurse should not disturb them because there is always an element of unpredictability with the patient. There is no sense in creating angry feelings in a patient because of your own thoughtlessness.

Summary Statement

In this section the nurses were able to reflect on the meaning and nature of CC. They were able to see the effect of CC on themselves, how the passage of time differed, that the process of CC was always changing and that they had a responsibility to be delicate with these patients. They offered many directives on how to care for CC patients and these were organized into the four categories of building a therapeutic relationship, preparing for CC, creating a sense of privacy and managing the violent or angry patient.

Coping

The nurses offered strategies that helped them get through certain CC situations. Two situations that caused most stress for the nurses were

CC at night and CC with an abusive patient. To ensure their own wakefulness at night the nurses suggested: reading books and magazines, writing letters, studying, knitting or crocheting, keeping the patient's room door open to ensure air circulation, drinking ice water, bringing a thermos of coffee, doing nursing care plans and asking other staff for relief so the CC nurse could go for a short walk. Susan recommended coming to work prepared to do CC at night; she would save tasks that needed to be done or would read a book that was light and yet very interesting. By reading something light she could easily distract herself and refocus on the patient if he required care and yet the high interest level of the book would keep her awake.

If a patient is abusive the nurse can rationalize the behavior and think, "people with this diagnosis act this way." Megan coped with violent patients by recalling that the other staff would help and support her if she needed them. After Anne had cared for a patient who had pushed her physically she coped by going home, and ranted and raved at her spouse. She said, "I couldn't do it at work, I had to do that somewhere safe." A number of nurses noted that abusive patients were overcome by their negative feelings and vented the feelings at the CC nurse but that understanding this dynamic did not help in tolerating abusive behavior. Terry described his own reactions and feelings in the following quote:

> There are limits to my tolerance, some patients, they can be taxing your ability to tolerate behavior continuously. I've observed some people almost lose control when they're upset, and I think I have not lost control when I'm angry about something. Maybe I haven't been pushed quite far enough yet, I just don't know. Right now, my irritation, frustration, anger is controlled. But constant care certainly puts me on the edge sometimes of my limits of control that way.

As the quote illustrates, he developed a coping style by observing others and monitoring his own reactions to certain CC situations.

Summary Statement

The nurses offered specific strategies for managing CC at night and nursing the abusive CC patient. Both events increased the nurse's level of stress and affected them physically and emotionally.

Interacting with Visitors

Visitors meant family members of the CC patient. Most of the nurses said if they had to be with the patient when a family member visited, they would read and not get involved. They would become "invisible" or "sit off to the side" and were careful not to make the family members feel like "there were under surveillance." Megan said that if she knew the family members she would "get involved, talk and explain things to the family." Anne agreed with Megan noting that often the family members needed therapy as much as the patient.

> Some patients have hardly any family involvement; their families don't come in at all, and other times the family will come in, and it's like they need therapy too. So you're sitting there and--and actually providing therapy for the patient and the family as well. And it makes the family feel much better rather than you ignoring them. 'Cause they have needs too. And they often get overlooked.
>
> Everybody's taking over their family member and they don't have any say in what's going on anymore so they need to be included. And I think lots of times patients on constant care feel really separated, from their family, from the outside world, from everything. They're isolated, they're like in solitary or something.

Anne recognized the needs of the family members, the drawbacks of CC and how she could unite the family and patient through her presence.

Summary Statement

Most of the nurses did not get involved with the family members. The ones that did demonstrated an understanding of the needs of the family and a willingness to nurse both the patient and the family.

CC at Meal Time

The nurses described their behavior while the patients ate. Susan and Anne tried to make the atmosphere more pleasant by suggesting to the patient to turn on the radio, assuring that the patient was comfortable and talking about light topics. Usually meal time was described as a "low danger time" but as Terry pointed out you still need to be alert because a psychotic patient could easily poke out an eye and so he watches what the patient does with the cutlery even if the patient has no history of self harm. Anne, like Terry, also checked the tray after the meal was over to see if any glass or utensils were missing. Meal supervision with anorexic patients was described as difficult, because the patient is usually anxious. As one nurse stated, "I'll sit and watch them because they are very manipulative and tricky in how they hide their food. It is their responsibility to eat and mine to see how much they ate."

Even though the nurses were vigilant during meal supervision they tried to create at atmosphere of privacy. Recognizing that the patient usually felt uncomfortable having someone watch them while they ate, a number of nurses resorted to reading, charting or keeping themselves busy with other tasks. Megan stated that if the patient felt uncomfortable she would sit out of the patients' line of vision so they would not feel stared at. As one nurse stated, "you don't want them to think you are

always focusing on and analyzing them." Meal time was a taboo time for therapy, it was viewed as the patient's own time.

Summary Statement

The nurses were very aware of the patient's need for safety, comfort and privacy during meals. Anorexic and psychotic patients needed to be observed carefully since both could engage in harmful behaviors.

Supervision of the Patient While in the Bathroom

All the nurses felt uncomfortable caring for the patient while they used the bathroom. Most of the nurses did not go directly into the bathroom with the patient. Instead they left the door ajar and stood outside the door constantly listening and frequently communicating to the patient. Terry said he "listened acutely and peeked in frequently"; Susan used the bathroom mirror to see what the patient was doing; and Garth said he was alert and called every five minutes, "are you all right?" The nurses allowed the patient more privacy if they were a different gender, trusted the patient or felt that their judgement about the patient was on target. To allow a patient to use the bathroom by themselves depended on the patient's illness, mood, medication, and whether they were very suicidal or impulsive. Even if the nurse did allow the patient to use the bathroom on their own, most explained they did not like it and felt "uneasy" or "unhappy" about doing so.

Only one nurse said she did not feel uncomfortable and that was if the patient required a great deal of direction and if she felt like she did not trust him. Also she felt comfortable allowing a patient she knew very well (three months) to use the bathroom by herself. She noted,

however, that no matter how she felt, she always stayed outside of the bathroom door.

Summary Statement

Most of the nurses felt very uncomfortable supervising the patient while he used the bathroom. The majority stood outside of the bathroom door and frequently checked on the patient. One nurse did not feel uncomfortable supervising patients in the bathroom when she recognized that the safety needs of the patients were more important than their needs for privacy.

Personal Preferences

> Usually the people I enjoy--the constant cares--are very psychotic patients. So any kind of good memory of constant-it's always related to somebody who is very psychotic, very delusional, hallucinating, who requires some kind of trust relationship being developed, low stimulation, quiet--quiet environment, lots of redirection, reality, orientation. There's just lots of activity happening, patient's usually quite hyperactive, responding, reacting to who knows what. I just like that, I find it very fascinating. That's what interests me in psychiatry.
>
> I like lots of stimulation, so that's why I like the psychotic patient.

Just as Susan liked the psychotic CC patients, as described above, Megan liked depressed CC patients:

> But some of the nicer experiences have been, probably with people who are very depressed or very ill, but are able to communicate. And I've had some really good--because you only have the one to look after, have had some really good heart-to-hearts with those patients.

The advantages of having "the type of patient who interests you" is that the shift goes quickly, the nurse can develop a trusting relationship, do a better assessment, talk about topics that are more meaningful, do extra

interventions like family maps, learn more about the effects of the illness, and may have the opportunity to see the effects of nursing care.

There were times that the patient slept through a day or evening shift and the nurse welcomed the opportunity to scour the chart and memorize the laboratory values. Another nurse enjoyed the opportunity to have time alone to read a magazine - knowing she was getting paid for it. If the nurse knew that the patient really needed rest it was easier to "let them" sleep during the day and to act as a guardian by not letting others disturb them.

Summary Statement

The nurses had personal preferences for the type of CC patient they wished to care for. There were also times when they enjoyed caring for a patient who slept during the day or evening shift.

Negative Experiences

> Well, one particular older gentleman comes to mind right away. He's very, very demanding, very abusive, nothing you did was right, and he was in bed--he was actually physically quite ill. He had chronic lung disease and a few other things and was on oxygen and intravenouses. But it was very difficult to stay with him eight hours. He just was almost constantly yelling, and nothing you did was right--just a very frustrating experience.

> Well there was one night when we had a patient that everyone on the ward had difficulty with this patient. She was very impulsive and manipulative, and very aggressive. And I was sitting with the patient and she was trying to leave . . . out the door, bolt out the door. And I got jammed in between the door and the wall. And I was trying to--like I was in a trapped kind of position, and I was trying to reason with the patient and remain calm, but I felt my own fear rising up in myself, and I'm trying to fight that and yet to calm the patient. And I didn't want the patient to see any fear in me and any loss of control, because then I felt the patient would get even more agitated and might do something even worse. I--I found that really . . . very negative. I felt . . . when I went home I felt awful about the day. And I was a bit angry at being bodily pushed aside. I felt that that was a violation of my rights as a person and as a nurse.

> I'm thinking of one patient we had, she was throwing herself against the walls and pounding on the window and tossing furniture around, well . . . being in a room with that patient a whole shift is draining just because you have no variety from it.

These descriptions were not unique to these nurses but a common experience for each nurse on the floor. Abusive, angry patients hurt the nurses emotionally and at times physically. The other negative experience related by the nurses were patient who slept all day (occasionally, as noted in another section, this was an advantage). Patients on CC who slept or spent long hours in the smoking room were viewed as boring and tedious assignments. CC at night was also rated as a negative experience particularly at 4:00 A.M. when it is the most difficult time to stay awake. Another nurse did very poorly with patients who had drug and alcohol problems. She stated that she could not identify with them at all and would if possible avoid caring for them. Just as the patients did not appreciate a nurse that did not communicate nor did the nurses appreciate a patient who did not communicate. Another negative experience involved the care of the patient who had been on CC for a long time. This patient controlled the nurses, made unreasonable requests and did as she pleased. Since it was difficult to accept the reason she had to be on CC for such a length of time, it was also difficult to care for her.

Summary Statement

Two extremes of patient behaviors - acting out and being withdrawn - proved to be negative experiences for the nurses. CC at night was also viewed negatively. One nurse did not like to care for patients who had

alcohol and drug problems and another resented caring for a patient who was on CC too long and therefore controlled the CC experience.

Supervisors

The Unit Supervisors felt that how a CC patient was nursed depended on the nurse's own philosophy and educational background, how the patient behaved (abusive or withdrawn behaviors), the nature of involvement, how the nurse used her presence, the willingness of the nurse to explain her own behaviors over and over again, the distance between the nurse and the patient at night or in the bathroom, the degree of trust between the nurse and the patient and the alertness of the nurse. Each of these themes will not be discussed because many are redundant when compared with the nurses' narratives.

New insights, though, were offered in the themes pertaining to the nurses' philosophy and the nature of the nurses' involvement in giving care. Sheila, in the following passage identifies how the nurses' philosophy of caring has a tremendous impact on her behavior towards the patient:

> . . . they don't see the patient as, this is a psychotic patient, this is how you treat this patient, you treat all psychotic patients this way. Some people come from that school of thinking in psychiatry, it's this diagnosis, you treat the patient this way. And you can see that in--that's how they intervene in constant care. And so they almost see their role as sitting there, not intervening with the patient at all and just letting him do his own thing, and only intervening when he's being a harm to himself, and not really interacting. I think, --other people will see the patient more as an individual, what--no matter what their diagnosis is, and will try to set up their care plan and that type of thing, and be more in tune with the patient. And they feel more comfortable doing it, they see the purpose of it.

The nurse who guides her interaction by a diagnosis is very different from the one who cares for the patient, irrespective of the diagnosis. This could even be extended to state "in spite of the diagnosis."

Kristen believed that nurses who were unsure of what was expected of them or did not know how to nurse a patient coped, by withdrawing from the patient. The nurses' withdrawal was evidenced by reading magazines, doing personal work like balancing a cheque book or writing letters, or sitting outside of the patient's room. Kristen gave an example of the consequences of one nurse's withdrawal.

> One of our patients fell out of bed and broke her hip on constant, because if you're looking at a journal, sometimes you get involved in the story you're reading and the patient --these things can happen with them being heavily sedated. So I say to them, sit right by the bed, if the patient's sleeping, you can read right beside the bed.

Jason and Donna used the analogy of restraint when describing nursing care. The nurse is a form of restraint which means she is not as strong as a lock (because restraints become undone) but her presence greatly modifies the patient's behavior yet may not ensure adequate safety. Jason's example of this is quite detailed voicing concerns about being alert, aware of unpredictable behaviors and knowledgable about dynamics of pathological behavior.

> When you're on constant care, you should be a hawk. Hawklike. I've witnessed patients on constant care, and if they really wanted to attempt anything, they can. Like you would virtually have to have them kind of strapped down to the bed, with all kinds of restraints. And then again, they can even bang their head or whatever and hurt themselves. What we were saying when you put them on constant care, or assign a patient to do constant care, that this person will be very diligent and vigilant and try to make sure that the patient doesn't come to harm. The fact that we allow patients to wear their own clothes--we don't strip them naked--it is quite possible

> for them to be concealing a razor blade or something. And then in that unguarded moment, they'll slit their wrist. Because incidents like this sometimes are unpreventable. Unless we do a strip search every morning. I've seen or heard patients eat their own feces. You know, go to the bathroom with the nurses there and stuff it and try to choke on it. You have to restrain every limb and the head, seal their mouth. Like if you're desperate enough to kill yourself, at the end of your tether, then there are ways of trying.

Donna adds another perspective when she points out that an incident on CC could have turned into a disaster had the patient not been on CC. In a way CC is a type of prevention but like all preventions they are valueless in proving what actually was prevented and to what degree.

Summary Statement

The Unit Supervisors and the nurses had similar descriptions about nursing the CC patient. Where they differed were in the comments about philosophy of care, nature of involvement, and the view of nurse as a form of restraint.

Administration

Patients

It was surprising and revealing that patients had so many observations about the administration of CC. They perceived themselves as consumers of health care, and as people who should be afforded certain privileges. For example, three female patients were adamant that they have female nurses. The patients felt so strongly about this that two of them made a special request to the charge nurse to ensure that no male nurses provide CC to them.

Another issue that all the patients commented on, was coming off CC. Jerry was most vocal about this feeling as reflected in the following remarks:

> I'm scared--I'm scared about this going off constant care. You know, on the other hand, there's a realistic time limit beyond which somebody's got to take a chance, I guess. Unfortunately that boils down to me taking a chance.
>
> I was not consulted in any way--to my knowledge. I had no input into that, to as to whether it was time to say, no more of that. And I'd said often enough at that time, I'm scared, and I want that person around, and that person is not around.

Others stated that they were not prepared and it was too abrupt. Wendy who went from CC to a weekend pass felt this was a strange transition and in turn questioned the value of CC. Coming off CC appeared to be more of a concern to the patients than being placed on CC. The root of this concern appeared to be related to the manner in which CC was discontinued - without patient involvement.

After being placed on close, Jay tested one of the rules of close observation which was that a patient could not leave the unit unaccompanied. He described his experience:

> I know I've walked all the way down to the elevator and I've walked all the way back, and nobody even knew I was gone. And then I knew, I sat there and says, now this is sick. I said, I could be on general instead of being on close.

From Jay's point of view there were two levels of care - CC and general which in turn demonstrates how abrupt the ending of CC was to him.

When asked what the reasons for being on CC were the patients answered with the following descriptions: being disruptive, dangerous, stupid, over dosing, and because of safety. Lucy thought most new

patients were on CC and that the diagnosis would be a factor as to whether or not the patient was on CC.

Due to previous hospitalizations, Wendy and Jay contrasted previous experiences of CC in other institutions. Wendy said CC was boring at another institution because the nurse sat outside of the patient's room and rarely interacted with the patient. In that institution, she saw staff as enforcing policies and not thinking about them. She also appreciated that she could wear her own clothing in this institution and that the ward was not locked. Jay stated that in the other institution he could not wear his own clothing. He saw this as an advantage because if you left the unit you could be quickly detected and if you left the hospital, the police would bring you back.

Relief staff for meals and coffee breaks proved to be a problem for a number of patients. Wendy thought they asked too many questions, she would have preferred to have a relief nurse that she knew instead of someone who just "filled in the breaks" with questions. Sally saw relief staff as "curiosity mongers," who would grab her chart and read about her. Some relief nurses saw themselves as nurses who had a right to engage in assessments whereas others saw their role only as guardians and the patients preferred the latter.

Jay was irritated being the victim of multiple assessments. In his words,

> And then the guy tells me what day it is. Then another person comes in right after again, and he does the same thing. Like you turn around and I sit there and I said, what's wrong with you people? You guys got no memory or something? It does get very irritating, like to have somebody come in and repeat over and over and over and over. It's--gets to the point where, hey, yeah, maybe I am absolutely nuts. Either I'm nuts, or these people are nuts, and they just gotta have me in here to

> keep them better. Like, to have somebody always constantly saying, go over this, go over it, go over it, go over it.

His quote reflects the lack of communication among disciplines, insensitivity to the patient's mental condition, and that multiple assessments of the patient increases the patient's discomfort.

The patients also had individual issues regarding the administration of CC. Jay thought all visitors should be screened and that CC patients be allowed to leave the unit; Jerry wanted a written description of CC and asked that the nurses be able to eat with him; Jenny felt that her CC nurse should not be reprimanded in front of her, and; Lucy thought there should be two kinds of CC, constant CC and semi-constant, and that the patient and the nurse should be matched. Lucy also indicated that the need for CC be carefully assessed, because:

> Constant's a really funny thing 'cause I think . . . unless people really need it, I think it's more harmful than good to them, actually. I think it gives you a very bad self image so . . . . It makes them angry, I think, most of them.

Summary Statement

The patients had a number of observations about the administration of CC. The main observations were that genders of nurses and patients should be matched, currently coming off CC was a problem, the patients understood the reasons for CC, CC at different institutions made them appreciate it at this institution, relief staff were irritating when they asked too many questions and were curious in their approach, and, having multiple assessments by different disciplines was irritating. Individual concerns were also mentioned by the patients. It was noteworthy that the

patients were able to give clear feedback about administrative aspects of CC and give recommendations to improve the experience.

Nurses

Each nurse make numerous comments about the administration of CC. During the analysis of data, this category was further reduced and classified according to the themes of support, reasons, problems, assignments and policies. Each theme will be discussed separately.

Support

Support came from patients, Unit Supervisors but primarily co-workers. It is an attitude or a feeling as in the words of Megan:

> . . . there's generally a fair bit of support amongst ourselves to help one another, and generally care a lot--I think really fairly good about getting us back-up and that. And that's reassuring, that makes it easier to do what you have to when they're like that. But--if you sort of feel abandoned with this . . . violent patient it's--it's--you know, you wonder, what am I doing this for, sometimes.

Support was also described as specific interventions or strategies. Garth describes how he gave support,

> . . . if I've got some nurse who's on constant care, I spend lots of time going in and out, saying are you all right? You want to take a break . . . . Go and have a cup of tea? I'll sit for an hour here, you can go to the desk and do a few rounds, checks, and so on. And I say to them if they are awake or something, I'll talk to them. Every night I can't do that, but most nights I can at least say, let's go in and see what's going on here. And I go in and give an assessment. I can pull them out of constant care and I think what the constant care nurses complain bitterly about is that they don't get the extra little relief and breaks and--and also break up their time because to sit for eights hours or so with just the official breaks, if you had a rough night and you didn't know that you're on constant care tonight, and some person phones you at seven o'clock and says, we want you to come in, we're desperate. And you says, I'm coming, and they says, okay, you're on constant care. And at two o'clock in

> the morning, you are just about (Dead) fighting. Winking and blinking and just trying--really, really desperate. And probably the patient is wide awake and keeping an eye on you saying, oh yeah, she's going to go any time. And I'm going to do my thing, whatever I'm going to do. And I think--oh, so I'll go in there and I says, you better go and have a cup of tea or a cup of coffee and stretch your legs. If you feel sleepy at all, if you want a break, you just let me know. And I think those are things that you gotta let people know.

Support also came from acting like colleagues which means being light hearted and socializing in report, asking each other for opinions and showing respect to each other. How to be supportive was learned by experience and role modelling. A number of nurses indicated that to have support you need to ask for it because as Megan stated, "others won't see it" so you have to make your needs known. Just knowing that immediate help was available made Terry and Anne feel supported. Both felt they could deal with a problem alone but wanted the reassurance of knowing that others would help if they were in trouble.

Reasons

The reasons the patients were on CC varied from medical to environmental factors. The most frequent reason was that the patient was considered a potential danger to himself or others and this type of patient was too psychotic, depressed, agitated or confused. Another reason related to patient threats. Two nurses felt that previously the medical and nursing staff rode out the threats but now the environment and recent suicides on the unit have shown that the patient's threats are to be considered seriously. A few reasons for CC were interpersonal in nature. One nurse said the main reason for CC was to help the patient, another said it was to provide control, the third say it as a temporary

state which helped the patient until the medications could take effect and the fourth saw CC as a prophylactic measure.

Problems

There were a number of problems identified such as prolonged CC, working nights, and having unskilled staff. Anne describes what it is like to have a patient who in her opinion has been too long on CC.

> So if you came across that in a therapeutic relationship as a nurse and patient, the patient would be angry because they wanted you to be their friend and their buddy, and they'd say, oh, I can tell you something, but you don't write it down, and--things like that. So it would degenerate the nurse-patient relationship--when patients are on long-term constant care.
>
> These patients would be on constant care for four months at a time--and that became a problem because then the patient became attached to some nurses, and they would be pitting staff against each other. And they would say, well, I want this nurse and not this nurse--and that kind of thing. And then the nurse-patient relationship was dissolved. And the patient didn't see you as a therapist but almost a peer.

Her description also indicates that staff morale was affected on the unit. She explained that the patient's doctor had been informed of the patient's behavior but the doctor would not consider the nursing staff's input in his decision to maintain the patient on CC.

The most frequent problem mentioned by all the nurses was doing CC at night. Nights is a time when it is suppose to be quiet and dark, and as Anne said, "you are supposed to keep it that way." Usually on night shifts the most unqualified staff are assigned CC and there is a problem maintaining a safe environment. For example, if a patient wants to go to the smoking room on nights (which is off the unit), the unskilled staff member may have problems stopping the patient from eloping.

Unskilled staff, which meant nurses from the nursing office pool and included senior nursing students and Registered Nursing Assistants, were viewed with skepticism. Terry alleged that "floats from nursing office are like adding another patient to your census". He added that some were not even interested in receiving a bit of report when covering for breaks. To him their behavior was like a defense--so they would not know what they were getting in to. Ruth concurred with Terry and added the following observations:

> Because they often don't even know what that medication is. Never mind what to expect of it. And besides which, they are often also not skilled in giving medication to a . . . objecting patient.

It seems ironical that the least prepared nurse would care for the illest patient. The staff understood this paradox but felt they had no choice, particularly on nights.

Assignments

The assignment of CC to regular staff versus casual staff raised a number of issues. Lorna, a nurse who worked casual said that she rarely is assigned the same patient two days in a row and yet she would greatly enjoy the continuity of caring for the same patient, as expressed in her own words:

> More comfortable for the patient, and a lot easier for you, because you know the person, you kind of know what to expect, and you can build up rapport with them if you've sat with them more than once. You know, they know you, and they kind of know what to expect of you, you know what to expect from them. It's just a more comfortable situation--usually.

The regular staff did not like the continuous assignment of CC because of the primary nursing system, the demands of being in charge and having to know all the patients on the unit, and missing out on ward activities. Terry pointed out there was no advantage to the full time staff doing CC with non-primary patients except for educational reasons, as explained in the following quote:

> If I'm doing constant care on a patient that's not my prime, I don't think it benefits me to have that contact. It may benefit me experientially because of my stage in my nursing career. And in one sense, I guess, the more one-to-one I do, the more valuable it is to me because I can then perceive how people interact. Because obviously--my contact with patients on the floor is somewhat less intense, or more superficial, than the contact I have one-to-one. And if I'm with someone who is diagnosed as hypomanic or whatever, or manic or paranoid schizophrenic residual or borderline personality, I mean, I can become much more familiar with those types when sitting constant care than I can out on the floor. For one thing, I have an opportunity to scour the chart. And in the chart there's just a wealth of information that there's no way I would get to if that person was not my prime.

Generally the rule is that a casual nurse is assigned to CC and Megan, who works as a casual elsewhere prefers CC because, "I don't have the hassle of trying to figure out 38 patients." Megan also pointed out that a casual is not automatically assigned to do CC. Other factors are considered such as who the casual is, the needs of the patient, the purpose of the CC, what has happened on the preceding shift and what is presently happening on the floor. She cautioned that occasionally casuals will have the attitude of "I don't get involved" and if you have a string of casuals with this attitude it will create a problem for the patient. Megan also observed that if you have a patient that is "right out" it does not matter whether regular or casual staff are assigned to them.

Assignment of CC on weekends versus week days was viewed as a qualitatively different experience. The weekends were seen as more relaxing, less stressful but also more boring. It was not a concern for the staff whether they did CC one week day versus a weekend, they just did CC whenever they were assigned to it. Anne did observe though that it was more difficult to get good staff for weekend coverage.

Susan and Anne both made a point of explaining the need to match the nurse and the patient. Susan also explains in the following description why female CC patients prefer female nurses,

> . . . the patient made a request for a female nurse constant, and I was trying to figure out why she would've made that request. And this has happened before where I've pinpointed the reason, what I thought was the reason. And I thought, well, all you have to do is look at her history--I mean, she was--there was sexual abuse, there was physical abuse, there was rejection from father, there was lots and lots of negative things related to male figures. And I thought, if I was her, I'd probably have all sorts of unresolved feelings towards men, lots of insecurities, and a lot of uncomfortable feelings. And I wouldn't want to be sitting in here alone, in a closed room, with this man who's watching--half-watching me bathe and half-watching me dress and . . . and--or even just sitting there in the room when I'm trying to sleep, and probably can't sleep, wondering if something's going to happen. You hear stories, that travel around in these chronic care centres where the orderlies have been messing around with the patients. You hear those traumatic things.

Anne, in her description explains how she considers the personality of the nurse and the illness of the patient when doing the assignments:

> . . . we had a nurse come on and we know for a fact that she's a very--very energetic and bubbly person and just full of energy. And we had a patient that was really, really depressed. Like almost a psychotic--well, this is psychotic depression. And that patient wasn't the type of person that could--that wanted to do things. And didn't want to be . . . carrying on a conversation and doing this and doing that. You kind of had to be very gentle and kind of guiding but not being . . . overpowering with that patient. So of

> course we didn't match those two together 'cause we thought it'd be hard on both people. So we tried to match that nurse with a patient that was on constant but was much more active and wanted to do things, and it would be beneficial for the patient to get out of the room and do a few things outside the room and that.

Policies

The policies, written and informal, pertaining directly to CC stimulated a lot of reaction. The ones that will be briefly reviewed are: nursing ordered CC, the patient going from CC to a pass, charting, CC nurse giving medications to the patient, use of security guards and the primary nursing system. The nurses are able to order CC and do so when the doctor cannot be reached or the patient's behavior changes and the doctor does not appreciate the actual confused state of the patient. Nursing ordered CC was not an issue because at least two nurses confer as to the advisability of putting a patient on CC and all felt supported by their Unit Supervisors when they initiated CC. The order for a patient to go on a pass immediately from CC, stimulated a very negative reaction in a number of nurses. This was seen as a "slap in the face", "crazy" and left the staff members feeling "startled, abused and angry". Susan said it made her lose her enthusiasm for the patient and that she had to contain her feelings of anger then with the patient. Charting also created a few problems since it is to be done every two hours and preferably not in front of the patient. Most nurses however chart in front of the patient, more frequently than every two hours and in the words of Terry, "occasionally fill the chart with extraneous details that deter anyone else from reading the chart." A few nurses said they were careful not to chart in front of paranoid patients and that they charted

only in the patient's room when the patient slept. The main reason nurses charted in front of patients was that it was too difficult to obtain relief staff so they could go to chart. Another policy that generated a mixed reaction among the nurses was that the CC nurse had to get relief staff so they could go pour medications for the CC patient. The advantages of the CC nurse giving his own medications were: knowing the medications given, getting a second opinion from the nurse who relieved you, and giving total patient care. The disadvantages were obtaining relief staff so you could go pour the medications and tampering with the nature of the relationship if the patient was paranoid about medications. The use of security guards created many negative reactions among the nurses. Generally it was felt that use of security guards demeaned the nurses, the utility was in only providing a presence, they were best used on a short term basis and that resorting to their use was custodial and a step backwards in providing nursing care. The last policy referred to the nature of primary nursing. A few nurses felt the primary nurse should do the admission and follow through with the patient. This would mean that if the patient required CC, the primary nurse would do as much CC as possible. The only difficulty with this was that a number of informal staff rules about CC existed such as: CC for not more than two days in a row, not after days off, not prior to being in charge, not at night if you are a regular staff member, not more than one in five or six shifts, and not for a 12 hour shift. Given the informal rules, the best a nurse could do would be to do the initial CC (if not on days off), to set up the nursing care plan and then to conference with the CC nurses giving care to the primary patient and to relieve the CC nurse for breaks in an

attempt to assess the patient. The nurses' reactions to the policies indicate that a few changes in practice could be made to increase their job satisfaction.

Summary Statement

The nurses' comments about administration were described by the themes of support, reasons for CC, problems, assignments and policies. Support was derived primarily from co-workers and was expressed abstractly as a feeling and concretely in terms of behaviors. The majority of the reasons for CC were reflected in the phrase, "a danger to himself and others." The three major problems associated with CC were working nights, having unskilled staff and a patient being on a prolonged period of CC. The assignment of CC referred to regular staff versus casual staff doing CC, the difference between CC on a weekend versus a week day, and the matching of nurses and patients when assigning CC. The last theme focused on policies which included nursing ordered CC, the patient going from CC to a pass, charting, CC nurse giving medications to the patient, use of security guards and the primary nursing system. The nurses had concerns about all of the policies, except for nursing ordered CC.

Unit Supervisors

The mandate for the Unit Supervisors is administration and the data reflected their interest and competence in this area. Common themes were identified such as the reasons for CC, relationship of the frequency of staff illness to the frequency of CC, length of time the patient was on CC, policies and the personal beliefs of the Unit Supervisors. Concerning the last theme of personal beliefs it became very apparent that each Unit

Supervisor held a different philosophy of administration and therefore priorized the needs of the CC patient and nurses differently.

Reasons

The reason for CC was clearly expressed by each participant as being motivated by the need for safety. The patient's behavior was described as unpredictable and the patient was judged to be a danger to himself or others. The decision to place a patient on CC (or take a patient off CC) was viewed by Jason as the doctor's responsibility for the patient. Sheila viewed the decision as a joint one among the nurses, doctor, occasionally family members and herself. Since the decision to place patients on CC has implications for the non CC patients, Sheila felt more responsibility for assessing whether the CC care order was appropriate. She observed that you need "very good reasons for starting and stopping CC but if the patient is not properly assessed, CC becomes the easiest and safest intervention."

The Unit Supervisors viewed CC as a necessary intervention that involved ethical, legal and moral issues. They were concerned that patients in the past had suicided in the hospital; and, that law suits had ensued because patients had claimed that they had not been provided with the proper supervision. The consensus among the administration was to be conservative and to raise the level of observation to CC rather than to take a chance with the patient's safety.

Staff Nurses

Two Unit Supervisors commented about staff illness. Sheila stated that when patients engage in a lot of acting out behavior the staff become tired and worn out. She observed that the frequency of staff illness

greatly increased after caring for a number of CC patients who required limit setting and frequent feedback as to their inappropriate behavior. Donna noted that staff illness increased when there was a high level of stress on the unit regardless of the number of CC patients. An example of a source of stress would be a patient who verbally or physically abused the nurses. However this patient would not necessarily require CC particulary if he or she had organic brain syndrome, since it would be assumed that this patient would continuously act in a confused, inappropriate manner.

Length of CC

The question of the length of time the patient required CC was raised by each participant. Each was concerned that the patient be on CC for the "appropriate" length of time. Sheila stated that a prolonged length of time for CC was not a problem provided that the patient was ill and that the staff members skills were being used appropriately. Jason noted that if the patient was on CC a prolonged length of time that the level of staffing decreased (Registered Nursing Assistants and student nurses were used) and therefore the care became more custodial since money needed to be saved. Kristen thought that the length of time a patient required CC could be decreased by providing good care, as reflected in the following quote,

> I just think by providing good nursing care that we can sometimes get them off quicker. And proper medications so that they're not going to fall or, that their thinking is as clear as it can be. When you have consistent staff, like permanent staff, I think I would be inclined to take patients off constant much quicker than if I had several constant care nurses coming in--security that you feel--if it's somebody that you can trust.

Policies

The formal and informal policies that were identified were very similar to the ones identified by the nurses. As listed they are: nursing ordered constant care, medications, use of security guards, continuity, and the budget. Nursing ordered CC was viewed as a valid order based on the nurse's assessment of the patient. One Unit Supervisor noted that it was used when the nurse disagreed with the doctor's assessment whereas another stated that the nurse and doctor agreed on the assessment but the nurse made her assessment prior to the doctor doing so. She viewed nursing ordered CC as a convenience.

The giving of medications was raised by two Unit Supervisors. The policy that the CC nurse should give medications to their CC patient was totally supported because as one Unit supervisor stated, "they trust you, it is part of the rapport . . . ." Both understood there could be exceptions to this policy but the exceptions would be rare. Providing continuity of care was once again raised as an issue. Sheila stated the problem succinctly as, "continuity for one or continuity for many." This meant that the primary nurse may provide CC for one of her primary patients and neglect the other three primary patients.

The use of security guards for CC patients was described with distaste. In the following description, Sheila explains why she does not want them on her unit.

> I really don't like having the security guard there. They are not trained very well in the understanding of mental illness, I had regular staff with him all the time, I kept preaching, any time you have a chance to teach the security guard, do so because many times they behaved inappropriately, there were uncomfortable in the situation, they felt that if they weren't utilizing their strength and their muscle, they weren't doing their job. And so they didn't feel good in the job either,

> so they sort of walk around feeling like they're not really doing their job either, and then you've got the nurse trying to interact with the patient, and you've got the security guard there as well.

The budget concerned the Unit Supervisors in different ways. One Unit Supervisor saw the cost of CC to be minimal, particularly, if you examined the cost of other interventions on medical-surgical areas. The observation was made that most CC patients who are transferred to a psychiatric unit from a medical-surgical unit are taken off CC as soon as they arrive on the unit. Therefore having a psychiatric unit actually saved the hospital money. Another Unit Supervisor had a different perspective and observed that "half the year is over and already the budget has been exceeded by 250 per cent because of CC." This view was supported by another Unit Supervisor who added that paying for CC nurses who were highly qualified also affected the budget.

Personal Beliefs

The personal beliefs of the Unit Supervisors influenced their descriptions of CC. This became most apparent when they discussed the role of families. On one unit the family was simply to be informed about CC and on another unit the family was to be informed and if possible asked to provide CC coverage for short periods of time. The use of the family for CC was seen as a prime opportunity to teach the family about the illness. Another personal belief referred to how a patient came off CC. One Unit Supervisor thought patients should be "weaned" off CC, for example, being on constant during the day and not at night. Another Unit Supervisor did not appreciate this view and recommended that the decision for the CC patient should be "either you are on CC of you're not." The

policy of having a CC patient go from CC to a pass upset all the Unit Supervisors except for one, who saw this as a transfer of responsibility from the hospital to the family. Two Unit Supervisors stated they wanted to have their units locked at night to ensure a safe environment for their patients. Another was totally against locking the unit at any time and thought that the provision of CC was a sufficient safety measure. The personal beliefs of the Unit Supervisors marked the differences among them and in turn how they managed the units.

Summary Statement

The themes that were identified include reasons for CC, relationship of the frequency of staff illness to the frequency of CC, length of time the patient was on CC, policies and personal beliefs. The reason for CC was primarily safety based on ethical, legal and moral considerations. Staff illness increased after caring for patients who acted out and were abusive. The length of CC was an issue when it was needlessly prolonged. Excellent nursing care was identified as a method of decreasing the length of time a patient was on CC. The policies that were raised referred to nursing ordered CC, medications, the use of security guards, provision of continuity of care and the budget. The personal beliefs of the Unit Supervisors highlighted how differently they managed the CC patients. Examples of beliefs included the role of the family, taking patients off CC, the patient going from CC to a pass and locking the unit at night.

Feelings

Patients

The patients had very positive feelings about CC as illustrated in Sally's statement, "I'd love to be on CC all the time" to negative feelings about certain aspects of CC, for example being denied the privilege of smoking in his room caused Jay to lash out and say:

> Like, if I quit smoking and I withdraw from smoking, I become so irritable and violent, not violent to the point where I'll just go beat somebody up. It's--where I will get very loud and boisterous, I will get angry and I will throw things around--I won't hurt anybody, but I'll do a lot of destructive damage.

Most of the patients, when asked to identify the remembered emotion when on CC, expressed their feelings in terms of safety. When on CC they felt protected, cared for, secure, calmer, more confident and not as fearful or frustrated. Marcia's description summarizes this feeling:

> I was just glad to have someone with me because I was so scared. That . . . and I was safe, I felt safe after being in the hospital after coming back from that terrible ordeal, after it was all settled down. I know I looked a sight, and my mouth was all cracked and sore and . . . and my hair, of course, was a mess, I needed to have a bath.

Since CC afforded safety, the patients had mixed reactions about coming off CC. Marcia said that after your off CC, "you're a little bit leery walking down the hall again, saying hello to people . . . you gotta do things for yourself." Wendy felt "let go of" and Jerry felt scared. Although Jerry recognized that he was scared he also admitted that a patient could get "so comfortable - so safe feeling - that you'd never

want it to stop" which would be a very untenable situation for all concerned.

Certain aspects of CC bothered each patient. Sally, Marcia and Jay felt embarrassed being watched while they ate; all the female patients resented male nurses because they didn't feel safe with men; Marcia resented wearing hospital gowns; Wendy and Lucy felt annoyed with the CC nurse when she stayed in the room when they had visitors; Jay and Sally missed their close relationships with other co-patients; Jay was upset that one of his CC nurses did not stay with him when he had a visitor because the visitor brought him drugs; Jay felt irritated that he could not leave the unit to get fresh air, that he was on CC at night and as previously noted Jay also didn't appreciate that he couldn't have cigarettes; and, all of them resented to some degree being watched in the washroom. Surprisingly this last observation did not evoke a strong reaction. This finding, though, was explained when the nurses were interviewed because most of them did not go into the bathroom but instead positioned themselves outside of the door and listened to the patient. If a nurse went directly into the bathroom it was because the patient was disoriented or confused. In contrast, a casual or float staff nurse would go directly in because she did not know the patient and the degree to which he could be trusted.

How the nurse acted and felt directly influenced how the patient felt. For example, one shift Colleen had a nurse who read the newspaper all day, she said:

> I felt a repulsion [towards her] . . . when a different nurse came on, I was so . . . relieved I got over-excited. I couldn't calm down, I was glad that I had--it was another--a nurse that I really liked, and I said let's go . . . . And

> I couldn't calm down because I had been so . . . negative all day, I guess.

Jerry had a similar negative experience with a nurse. This nurse sat beside him and didn't speak which greatly distressed him, as he said, "I'm supposed to be the one with the problem. Oh, she blew my mind, that lady. That was a record". Lucy observed that there were some nurses who were upset at having been assigned CC and as a patient you could sense their feelings. Jenny was present when one of her nurses was reprimanded by the Unit Supervisor. She said, "that hurt me too, her getting heck like that . . . it bothered me. Now, even just thinking about it, it bothers me."

CC also made the patients feel really cared for and cared about. Jenny described this experience with one of her nurses.

> I felt it was done as a joint act. That I was never pushed into doing things. I was considered. Like if I wanted to go for a shower or if I wanted to go for something to drink, or if I wanted to go here, then we would go there. So I would have to say it was a joint, joint caring. Both caring about me. But me caring about her, too, in the same sense. Not the same way she was caring for me, a different kind of caring.

A feeling that was identified by each participant was trust. This was not picked up by the investigator until the Ethnograph had been used to sort all the categories. There appear to be degrees of trust - when you are on CC you are not trusted but you may be trusted "enough" to have visitors or to use the washroom by yourself. Coming off CC meant that you are trusted "to seek out a nurse," "completely trusted" or "trusted by them but not necessarily by yourself." The goal of the nurse-patient relationship is to trust each other, however the feelings of trust are variable on an hour to hour basis and yet established over a period of

days and weeks. The patients had a view of trust that needs to be explored in greater depth.

Summary Statement

All of the patients appreciated the need for and even liked CC, with negative feelings being directed to certain aspects of the experience. The patients recognized that the nurse's feelings affected them directly and the continuation and termination of CC was somehow related to the feelings of trust.

Nurses

In contrast to the patients, the nurses had mainly negative feelings towards CC. Garth described what every nurse alluded to,

> I'd be lying to you if I tell you I'd like to sit constant every day of five days a week. It's a very tedious and at times boring and unstimulating part of nursing.

Other feelings voiced by the nurses were: confined - "you can't go to the washroom when you want to;" fear - "patient will act out and I can't leave;" resentful - "misses out on relationship with other patients;" taxing - "when level of arousal is constantly high;" rude - "when invading privacy of patient;" frustrated - "no formal consultation, unable to discuss patient with doctors;" uncomfortable - "observing patient in bathroom;" boring - "focusing on same old drudgery;" insecure - "don't know new patients;" angry - "it's a slap on the face when a patient goes from CC to a weekend pass;" pain - "doing a CC on a manic, aggressive patient;" scared - "violent patient;" annoyed - "multiple interruptions and noise from intercom stirs up patient;" trapped - "you can't vent your

anger on the patient;" frightening - "working with a patient who also happens to be a nurse;" stressed - "sitting with someone who misinterprets what you're saying and threatens you;" embarrassed - "to watch them eat;" and, dreadful - "if your tired." These feelings were shared by all the nurses, but were mitigated by several factors. One factor was the patient's behavior. None of the nurses appreciated giving CC to a violent, aggressive rude, sarcastic, demanding patient. Another factor was the patient's diagnosis, particularly the diagnoses of being alcoholic, borderline or anorexic. Susan enjoyed working with psychotic patients and Megan with depressed patients and if they were with their preferred patients they had more positive feelings about the experiences. A third factor was how well the nurse knew the patient. Often if the nurse knew the patient it was easier to do CC, unless the patient was violent or rude. Conversely, if the patient had been on CC for too long it was also difficult to sustain enthusiasm for CC. The fourth factor was the support the nurse received while doing CC. Negative reactions were engendered when the doctor showed no appreciation of the nurse's work, when the nurse was not allowed to have the light on when doing CC at night or when the same nurse had to do too much CC or at the wrong time in his rotation. The last factor was the nurse's own fatigue level, particularly if he was tense the entire shift or had to do CC at night and was tired before beginning the shift.

The word trust was also used frequently by the nurses. They mistrusted the patient particularly if the patient needed a lot of direction or was intent on killing herself. The mistrust was most problematic when the patients were in the bathroom. The nurses felt

uncomfortable being with the patients in the bathroom and wanted to give the patient some privacy, so they mainly stayed outside of the bathroom, but this created a dilemma for them. Terry described his feelings about this situation when he stood outside of the bathroom door:

> Because I'm never absolutely certain, whoever it is on constant care, that they will not do some self-mutilation, even if they have no history of it in the past. I'm just never absolutely certain of it. Because I feel that . . . their thinking is out of control enough that I just don't know what thought might pop into their heads whether they're, you know, obviously suicidal because they're depressed, or if it's the voice saying, you must do this to yourself. So, it's a risk I take and I'm not happy about that.

To spend hours with someone you do not trust, who perhaps does not trust themselves is draining, particularly when the consequence is death.

Summary Statement

The overwhelming feelings of the nurses towards CC was negative in nature. The types of patients, support, feelings of mistrust, how well the nurses knew the patient and the nurse's own fatigue mitigated their feelings toward CC.

Supervisors

The supervisors described what the patient and staff felt about CC and included their own personal experiences. Sheila captured the ambivalent feelings of the psychiatric patients as depicted in the following quote:

> Some patients don't like it because it feels like an invasion of their privacy, particularly if they're going to the bathroom or--it just feels like you've always got somebody tailing you and watching every move you're making. And it makes you feel . . . well, in an adult environment, it doesn't make you feel like you're in control of--of your own self.

> Some patients like it, though, because it makes them feel more safe, makes them feel more comfortable. And they're frightened to be on a psychiatric unit, for example, or they're just frightened, so they feel more secure having that nurse with them all the time.

Donna, too, recognized the ambivalent feelings of the staff members and gave an example of nursing an anorexic patient, as described in the following quote:

> . . . our anorexia patients are a good example. Leaving the bathroom door open while they're in the bathroom, and actually seeing the patient so that we know they're not dumping something in the sink or whatever--we have to do that. And I know personally for me, I don't like doing it, and I have had to do it with patients I have here now. And I know my staff don't like doing it either. They don't feel comfortable about it. And I know that the patients don't like it. But it's--it's a way of keeping them alive. And they usually come out of it and are grateful.

Trust, was mentioned again, as a concern in nursing CC patients. Kristen said that with some CC patients you could develop trust very quickly but if you were going to sit with a patient for a half hour relief break the best you could do would be to observe the patient with no hope of forming a relationship. As well, if you have a violent patient that "on guard feeling" will not let you develop feelings of trust.

Kristen also pointed out that feelings were reciprocal between nurses and patients and that patients will pick up the nurse's anxious feelings. As well, if a nurse really enjoys CC and looks forward to doing it, the patient will feel better mentally and physically.

Summary Statement

The supervisory staff recognized that CC created ambivalent feelings for patients and nurses. They also noted that trust was an issue, particularly for relief staff and that feelings were reciprocal.

Others

Patients

The category "others" included doctors, visitors, patients and other staff on the unit. Although the patient was on CC and always with a nurse, the presence of another person aside from the nurse was still extremely significant to the patient. The relationship the patient had with the doctor was very important to the patient. The worth of this relationship was reflected in the positive and negative comments made about the doctors. This is illustrated by Sally's comment, "as long as I see the doctor in the morning and listen to what he says, I almost feel like I don't need nurses the rest of the day" and in contrast, Jay's comment:

> Like, it's like as if my father--like just died yesterday. And the doctor doesn't understand nothing like that. I feel frustrated and angry at him to the point where I wish I could take him and throw him over that balcony. But then I say, look it, he made a mistake. But if something does happen and does go wrong, I'm--I probably will file a lawsuit against him.

The patients wanted the doctors to really "know" them, listen, be clear in their communication, supportive, identify their rank (intern, resident or staff), teach them new skills and to include the nurses in the doctor-patient conferences. Jay felt that the doctors were too authoritarian

which meant that he felt excluded from the treatment plan and resented the fact that he was treated as a child. Jerry echoed Jay's remark and stated, "my doctor does not give me choices, I have no input and I am not considered and yet I feel very suicidal."

Six of the eight patients smoked and each one of them commented on the reactions of the other patients whom they met in the smoking room. Other patients reacted to the CC patient by making, as Colleen said, "funny little comments . . . oh you still got your shadow or when are you going to smarten up and get off CC . . . . They saw it as a punishment . . . they don't ask you if the nurses are helping you or whether the nurse talked to you, just the fact that you had one." Other observations about the co-patients' reactions were: being teased, left out of a conversation because you can talk to a nurse instead, loss of status and control, viewed as strange or really out of it and curiously because the co-patient would ask why or what happened. The CC patients who smoked commented about their experiences in the smoking room when they were off CC, and noted that there was an intimacy among the smokers that did not exist with co-patients on the units. Jay called it group therapy, Sally liked the friendships and Colleen felt like an instigator and described herself as a group leader who made the other patients laugh. Colleen also valued the positive feedback she got about her appearance. The topics discussed in the smoking room ranged from food to how to get along with the doctors and nurses. One of the benefits of coming off CC was returning to freer, personal discussions in the smoking room.

As noted in the feeling section, the patients had mixed reactions about having visitors and being on CC. Lucy was very embarrassed having

visitors while on CC because as stated in her own words, "you know, your visitor thinks, my God, how nuts is this person? It gives the impression to the visitor that you're really quite ill." In contrast, Colleen stated, "I really enjoyed it when they (nurses) were with me and my family . . . . My kids abuse me . . . they take me for granted." Colleen appreciated that she could talk to her CC nurse during and after a family visit. She felt the nurse understood the family dynamics and in turn taught her how to be more assertive with her children. Another patient was appalled that the CC nurse did not stay with them when he had a visitor that offered him a hit of acid and some cocaine. He concluded that all visitors should be screened. Whether a nurse is present when a patient has a visitor is dependent on a doctor's order. In this institution, visitors are assessed informally by the staff to determine whether this patient should see a certain visitor alone or with the CC nurse. Judging by the patient's reactions, these assessments and consequent decisions need to be made more frequently.

The last theme in this category of others, were the references to other staff which for these patients meant nursing staff, unit supervisors and security guards. General comments were made about the staff such as they were wonderful, supportive, interested, friendly and nice. These comments were not solicited but offered spontaneously when answering questions about the nursing care.

Summary Statement

Others (referring to doctors, visitors, co-patients, and nursing staff) were very important to CC patients. The relationship with the doctor was very significant to the patient as evidenced by the nature of

the negative and positive comments. Co-patients, who smoked, noticed the CC status and would act differently to the patient. The patients had a very mixed reaction as to whether or not the nurse should stay with them when they had a visitor. Lastly, they commented favourably about other staff members on the unit. This category illustrated that CC does not mean a psychological interpersonal prison but that it is an open, interactive process among the CC patient and significant others.

Nurses

When the nurses referred to others they mainly referred to the doctors, and occasionally to co-workers, other patients, clergy and visitors.

A number of issues referring to points of conflict in the doctor-nurse relationship were highlighted. The first issue, namely how, why, and when a patient moves from CC to close as ordered by the doctor, was raised by Terry:

> There've been other times where I've made suggestions about observation level, and--like, no, don't put the person on general and they have gone ahead and put the person on general from close. Like, I've been perhaps more cautious than they have. But that's not a big concern. And someone coming off constant to go onto close, well . . . I find that sometimes hard to determine because sometimes I feel that I almost lose my objectivity when I'm in a room with a patient, sitting constant. Because--it's like I lose perspective of--of the acuity of the patient. It's like I sense that . . . boy, is this person sick. They'd better never be let out of here. And then the psychiatrist will come in and talk for a few minutes and say, oh well, she can go on close. And I find that interesting. I could take it as undermining . . . of my assessment or authority . . . not that I have authority as a nurse.

Terry's description acknowledges how the CC experience could contribute to a myopic view of the patient and yet the way the transition of the CC to close occurred, diminished the nurse's sense of self worth. Susan, echoed Terry's observation but countered the myopic view. She felt frustrated because she had not been consulted about the patient, in her words:

> Somebody comes in and suddenly all of these major decisions are made that are going to affect that person's care for the next week or whatever, and you've been with the patient for eight hours or whatever, you've been with him all day, or all the previous day, or all the previous week, and suddenly it's just changed . . . . Lots of times you aren't consulted. There isn't a formal consultation where they directly come to you and ask. Lots of times your notes aren't even looked at. It's just based on this brief little interaction. And that's frustrating.

Another issue referred to what degree the patient was involved in the decision to come off CC. Susan noted that some doctors addressed specific questions to the patient, such as, "how do you feel about coming off CC? are you ready?" but felt that most doctors did not involve the patient. The doctors that did involve the patient provided a standard of care that contrasted sharply with the usual medical care.

The decision to place a patient on or take him off CC, created a few problems because the nurses did not always agree with the doctors' assessments. Megan observed that the doctors do not order CC for patients who "wander around and get lost"; Garth felt that a certain doctor ordered CC at the earliest threat of "anything"; Susan thought CC was used inappropriately on admission and replaced the act of making a proper assessment; and, Garth guessed that a certain doctor placed patients on CC just to increase the level of care.

Another issue was the lack of respect shown to the nurses by a few doctors. Anne was the most succinct in describing her feelings about this attitude:

> There are certain doctors that make that decision independently. They often will not listen to what staff have to say. They decide that they know better, and they give the order. So ultimately we have to follow through with the order.
>
> They're going basically on their own data, their own perceptions, and not really taking the nurse's word. Even in a conference when a nurse has input, it's kind of like it's trivial to them.
>
> I don't know what their motivation is. I think that basically they feel that a patient is there for medical treatment, and we're just there to provide the medication for the patient and to ensure that they are looked after, but we're not really doing anything in terms of their treatment. We're just following through what they tell us to do. We don't have any independent thought.
>
> It's frustrating for a lot of nurses, they feel that their knowledge--is not being taken to account, and they're not being treated with respect.

The last issue that was identified by Anne and Ruth referred to the clash between the scientific medical approach and intuitive nursing approach. Both nurses felt that to communicate with the doctors you had to put "yourself in their mind set, try to disassemble your own views and reconstruct and express them in a way the doctors could understand them." Ruth explained that if you tell a doctor your "gut feelings" he will not give you any credence; instead you use his language and he will listen to you. She was also careful to refer to behaviors that the doctor had observed but not necessarily identified in a holistic manner.

Ruth had a number of beliefs that referred to others. She felt that only close family members should visit the CC patient and that any other

visitor was a curiosity monger; other patients could help care for the CC patient if they were invited to and were happy to be needed; and, co-workers were invaluable for their knowledge and should be used on a consistent basis for soliciting second opinions. The one profession she had concern about were the clergy unless they were trained to deal with mentally ill patients. The following description highlights her concerns:

> If they're hospital clergy, then they've been trained to deal with psychotic behaviors. But if it's not hospital-trained clergy, they can do more harm than good half the time, it isn't--because they wish to do more harm. It's not, they really come out with a sense of caring. They don't know how to deal with it, and a very good example of that was a patient recently who was having the hallucination of seeing the devil and an evil cloud in her room, and a clergyman who was not familiar with psychiatry--and not trained to deal with psychotic behaviors, who came and prayed for the evil cloud to leave the room. Which, all it did to her was, it reinforced that it really was there. And when asked if he in fact did see the evil cloud and the demon in the corner of the room, he said, of course not. And we said, well, she did. And when you prayed for its removal, she thought you saw it too. And he just was absolutely astounded. So it can do--harm.

Summary Statement

Referral to "others" by the nurse meant the doctors, with a passing reference to co-workers, patients, visitors and clergy. The nurses perceived themselves to be in conflict with certain doctors because of the following reasons: how, why and when a patient moves from CC to close as ordered by the doctor, lack of involvement of the patient when taking the patient off CC, different assessments of patient's behaviors between doctors and nurses, lack of respect shown to nurses, and, lack of appreciation by doctors for the nurse's intuition when making assessments. Judging from the nurse's reactions to certain doctors the conflict between

them should prove to be nontherapeutic for the patients. Passing reference was also made to restricting visitors to immediate family members, using co-workers in making assessments, asking other patients to assist in caring for CC patients and screening the clergy to ensure they do good and not harm.

Unit Supervisors

When the Unit Supervisors talked about others they referred to the doctors and families.

Doctors

The Unit Supervisors gave examples of positive interactions between themselves and the doctors. One Unit Supervisor summed up the relationship in the following statement, "some doctors allow less of my input but most look to us for our assessment." Two Unit Supervisors thought that certain doctors placed patients on CC "hastily." For example, patients will be placed on CC on admission, if they make any threats or are suicidal and yet patients with these characteristics assigned to another doctor will not be placed on CC. Residents (doctors training to be psychiatrists) were viewed as very cautious and quick to place patients on CC. They communicated the attitude of "be safe rather than sorry." All the Unit Supervisors felt they could disagree with the doctor's assessment which allowed them to initiate nursing ordered CC but they did not want to discontinue doctor ordered CC. The reason for this was expressed in the following quote,

> So I know some people have difficulty in saying that the doctor's the head of the team or is ultimately responsible, the way the system is set up here, the whole health-care system, they've put the doctor at the top. We don't have as

> much "team" as we say we have. The final decision seems to come from the doctor.

The same Unit Supervisor noted that even if you disagree with the doctor, "the policies won't back you up."

Families

The role of families in caring for CC patients was mentioned more as an idea rather than an actual event. The following quote demonstrates why family members need to be involved in the care of the patient.

> But I think that families could be used at times to do constant care with their family members. And they have a really good rapport with them, and I think that they can be very helpful in working with the patient and helping them understand what's going on, or making them feel more safe, I really see nothing wrong with having the family involved, having them spend time sitting with their family member. And I think that it helps them have a better understanding of the mental illness that their family member's going through--what's happening to them and how they can help, in a lot of ways. Sometimes it's--detrimental to the patient but then you have to assess that, and of course, it could be a family member that's making them feel ill.

One Unit Supervisor pointed out that the use of families to provide CC has to be a doctor's order. This would limit the involvement of the families to do CC because the doctor, not being present 24 hours, would not have time to assess the capabilities of the families to provide care.

Summary Statement

The two groups that the Unit Supervisors referred to were doctors and families. They regarded the doctors as cautious, ultimately responsible and open to their feedback. The families were seen as a source of potential support to the CC patient but currently their role in caring for the CC patient has not been developed.

Environment

Patients

The patients were not very concerned about their environment while on CC which is appropriate given the severity of their illness. Jenny observed that in fact the CC nurse created the patient's environment. In her words, "if you have a really good nurse, I think she would make you try not to feel like you are cooped up and you are tied down. I think that would make a difference." Colleen, who was on CC a long time, felt that she should be able to walk to all the psychiatric units rather than just walking "in a circle" on her unit. Wendy preferred having a room mate because then there was more going on whereas Jerry thought it was awful for the nurse to sit CC at night in a semi-private because she had to sit in almost total darkness. Jay thought there should be a common eating room, he described it this way,

> You can sit with the people you like. You can sit there and you can eat and talk, and you can take your time in eating. And it's a lot easier, and I think it speeds up the recovery a lot more. Because it opens them up and it sort of brings everybody into a big group. And that's where a lot of group therapy happens.

He also observed that currently the smoking room provided patient-initiated group therapy that could take place in a common eating room. Jay also really missed having fresh air. He wanted to "go by emergency and stand out there and breathe."

Summary Statement

The patients were not concerned about their environment. They made a few observations such as the nurse creates the patient's environment,

having a larger area to walk in would be appreciated, one patient preferred having a room mate and another did not, having a common eating area instead of eating by yourself in your room, and being able to breathe fresh air were mentioned. The patients must have found the environment to be pleasing and therapeutic since so few observations were made about it.

Nurses

All the nurses were concerned about the hospital environment. Themes that were identified included the building, CC in a private versus semi-private room, noise levels, and a monitoring system. Nurses who had worked elsewhere compared the current environment to previous ones and found that although this was a "modernized" setting it had other major drawbacks in terms of safety and inhibiting socialization among patients.

Building

All the nurses commented on the architecture of the building. Garth clearly expressed their attitude when he said, "this building holds us to ransom." Since the psychiatric units are not on ground level the patients are able to jump over a railing to their deaths if they feel suicidal. Previously the patients had to walk a mile to jump off a bridge if they intended to commit suicide. During the walk they could "cool off" and consequently control their impulsive behaviour. In this institution a bridge to jump off is within seconds of their intentions.

Anne made a number of observations of how the unit itself did not provide a safe environment. In the following description she critiqued the structure of the unit noting how unsafe it was for the patients.

> Like, in terms of where the nurses' station is situated, you can't see all the rooms, you can't see who's coming or going from the unit. There's no patient common area to know where patients are. They wander off--it's hard to keep track of who's who and where they are, especially if they're on general observation. We are not aware of who is out there, when the doors should be locked and when they shouldn't be locked. Even the back room, where the utility room is, there's some things in there that are dangerous; they're kept out in the open and there's no other place really to keep them; there's no storage places that are safe, other than the med room itself which is totally occupied with other things.
>
> The B.P. cuff right above the bed is a great place for hanging yourself, 'cause it's really--it's firmly attached to the wall.

The area that serves as a meeting room for the patients was viewed as a "bus waiting room" by Anne. In her words,

> I find even as a nurse, sitting there, you don't feel comfortable. You feel like you're in a bus waiting room or something, you know, that you have to sit there for a while but get out. You don't sit and hang around, 'cause there's all this traffic and people. You just feel like you can't sit here for long, just do your business and get going.

She also pointed out that this was the only communal area where patients from different units could meet to socialize. The smoking room, currently serves at the communal meeting room. Anne questioned how therapeutic the room was,

> You often will see one central figure in the smoke room acting as therapist to other patients in the room. And the patients will say a lot of things that they won't say to their nurse, and they act in a very different way. And there seems to be kind of a comradeship there. Like, we're in this boat together, so we can trust each other, but we can't trust them --they're out there. And even with the nurses sitting outside the room, that even makes them and us an even more--more of a . . . an issue. But, like I say, I don't know many nurses that want to sit in there and be fumigated.

Anne also commented on the environment of the patient's rooms. She stated, "with all the policies and regulations you can't do anything to personalize your area." Since patients are not allowed to hang anything on the walls or change any art work currently on the walls, they are restricted in creating a personal environment. This could be an issue for a patient who is on CC for a long time.

Room Mates

Heather, Sally and Anne were very alert to the difference between CC in a private room versus a semi-private room. The room mate, depending on who they were, had the potential for being very positive or negative towards the CC patient. Anne noticed that how the room mate responded to the CC patient "set the atmosphere in the room." If the CC patient irritated the room mate, the tension increased and set the tone for the day. To avoid problems, she stated they tried to match room mates,

> We think about it carefully when we put people together. Especially if it's patients we know. We try to match somebody that won't irritate the other or get their symptoms going, so they won't make each other worse.

She also noted that the room mate had to be acknowledged and deserved some explanations about the CC intervention. Heather saw many advantages in having a room mate because it took the intense focus away from the CC patient, it varied the level of stimulation for the nurse, assisted the CC patient in interacting with others and "normalized" the CC experience.

Noise

Megan was very aware of noise levels, as she described in the following quote, "one thing about being on constant I've noticed is the impact of the noisy high heels and noisy conversation, and just the

general noise in the ward." She also explained that the noise levels were different on days, evenings, nights and weekends. In another institution where she works on a casual basis, the use of the intercom greatly annoyed her because, "you'll just get someone settled and then the voice on the intercom bellows 'Come and get your dinner'." She explained that since the units are so small in this institution the intercom is never used and rather than announce anything on the system you go directly to the patient to tell them anything. Megan also felt irritated when the patient had multiple interruptions. She explained,

> With some patients you don't want to be interrupted a lot because every time they're interrupted they're stirred up. That can happen more in the week because the cleaning lady and the student nurse and everybody pops in, and if you have someone that's quite responsive to that kind of thing, then that can be irritating.

Monitoring System

The nurses felt the units were too open and since the nursing station was away from the doors they felt they lacked awareness of which patients left the unit and the type of visitors that arrived on the unit. Susan recommended the establishment of a monitoring system to assist the nurses. She explained her recommendations in the following quote,

> Why is there not maybe a reception area right out there where somebody is, a receptionist of some type who could monitor the comings and goings on the unit, who would be in control of a door system of some type, who'd be able to direct family. So you would know, who's coming, who's going.

Terry made an interesting observation about the value of locking units. He explained that controlling or monitoring patients by locking the unit had undesirable ramifications; mixing patients who are mildly

neurotic with patients who are actively psychotic would lead to friction among the patients. The end result of this friction could be an escalation of the psychotic person's behavior, violence against a co-patient and marked discomfort for certain depressed patients. He also saw the potential for law suits when forcing patients to co-inhabit a restricted space.

Summary Statement

The nurses were very concerned and alert to the lack of safety in their environment. The building was described as very unsafe because it provided many avenues for the patient to commit suicide. The lack of a communal meeting room for patients, excluding the smoking room, was viewed as a architectural deficit. Also policies restricting patients from being able to personalize their rooms were seen as undesirable. Room mates, of the CC patient, were viewed as a positive influence, if they were well matched. Noise and interruptions were irritating particularly if the CC patient was hard to settle. The need for a monitoring system included the use of a receptionist and use of locks to control patients' movements was not recommended. The nurses were alert to potential hazards and in turn were able to make specific recommendations to improve safety in the patient's environment.

Unit Supervisors

The Unit Supervisors were completely focused on safety. Like the nurses they saw the location of the psychiatric units as an "open invitation" to attempt suicide. Two Unit Supervisors felt strongly that the door leading from the psychiatric area should be locked at night.

Apparently they had attempted to have a policy implementing locked doors at night but the administration of the hospital had refused to sponsor such a policy. Both Unit Supervisors expressed concern and frustration at the administration's inability to understand how difficult it was to provide a safe environment on nights. The following quote highlights these feelings.

> When we were first giving some input into the locks on the unit, as supervisors we were concerned about the safety of the patients. And then we had other people who had more power in the system, but no experience saying you'll be curtailing people's free movement. We're talking about patients who are sick. We're talking about patients who we're supposed to be providing a safe environment for. They were concerned about all the people who may want to come to the unit. Well, you tell me why people want to come at twelve o'clock in the night.

One Unit Supervisor stated that a private room was the best for anorexic patients because you had to lock their bathroom and patients with a medical problem needed a private room because of the "space consuming" equipment. As well, if they were in a semi-private, the curtain drawn around them was "too shroud-like" and constraining. However, the Unit Supervisor added that to meet the needs of each patient was impossible and that others did not realize what an "incredible juggling act" was required to maintain a good level of care to place the patient in a room (private or semi-private) that was appropriate to their needs.

Summary Statement

The prime concern of the Unit Supervisors was safety. This was expressed in terms of the location of the unit and the need to lock the doors at the entrance of the psychiatric units at night. One Unit

Supervisor preferred to place CC patients in private rooms but recognized this was not always possible to accomplish given the multiple demands of each patient. The Unit Supervisors were not as concerned as the nurses about about safety in the patient's environment.

Alternatives

Patients

The patients suggested very few alternatives to CC which reflected their appreciation of this type of care. In fact Jay stated that CC was much better than "being strapped down to a bed." Lucy and Jerry both recommended that there be two levels of CC. The first level would be CC as it is currently practised in this institution and the second level would be a close-constant. Lucy saw this as less intense and involving five minute checks. Jerry described the second level as the nurse acting as a participant-observer. In this role she would keep the patient awake and thinking but not demand anything of the patient. If she distanced herself emotionally and intellectually from the patient, the patient could maintain his sense of privacy and be guarded by the nurse at the same time.

Summary Statement

The patients offered few alternatives to CC. The alternative mentioned by two patients was to downgrade the intensity of CC by having the nurse resort to five minute checks or distance herself emotionally and intellectually from the patient.

Nurses

The nurses generated a number of alternatives to CC but ones they did not necessarily support. For example, Sally said, "over medicating is an alternative but I certainly don't agree with it." The alternatives can be listed, and include: locked doors to the unit or room; no alternative, providing a safe, secure environment; moving the psychiatric units to the ground floor; devising a close-close system whereby the patient is checked every 10 minutes; being firm with patients and giving them strict guidelines which everyone follows; restricting patients to their rooms; having a receptionist to monitor patient activity; use of security guards; good nursing care; medicating; one-to-two or one-to-one where the nurse could leave the patient to get medications and allow the patient to go to the washroom without supervision; flexible CC - if the nurse really knows the patient; patient sitting in the smoking room; use of an isolation room; use of peer pressure (milieu therapy); making patients responsible for their behavior (sending them a bill if they damage hospital property); changing the philosophy and medical leadership of the unit; and involving all the patients in a ward program rather than allowing them to isolate themselves.

The alternatives focused on the themes of safety, the use of nursing, judgement and provision of excellent care, and changing the ward philosophy and medical leadership. Safety, referred to the use of locks, location of the unit, and ensuring access to an isolation room. Ruth, felt very strongly that if she was in physical danger, an isolation room was essential. She describes her feelings in the following quote,

> Patients would say put me away in a room, because they knew they were getting upset or out of control. We put them in

> that room. And then they would rant and rave and hallucinate, we had patients that took one of those steel bedpans and threw it against the doors and walls to the point where it was nothing but a mangled little ball of metal, unrecognizable as a bedpan. Who needs to be doing constant care with somebody like that. An alternative to constant care, where they're very, very threatening, is isolation. You would have less of these assaultive behaviors. If they want to injure themselves, they can't, and at least the patient feels safe, and so do you.

The use of nursing judgement as an alternative to CC was reflected in the recommendation of a close-close system or the use of frequent checks. The nurses who felt they had a degree of trust and knew the CC patients, thought they could be more flexible and trial the patient with five minute checks. The alternatives reflecting excellent nursing care focused on the use of behavioral control. Jerry observed that patients' behavior could be controlled with verbal interventions rather than automatically restoring to the use of CC. He also was adamant that security guards were no alternative to CC but rather a step backwards.

A number of nurses observed that the CC hours were very high in this institution compared to other places they had worked. The reasons for low CC hours in other institutions were no staff available for CC, having locked units and providing a different milieu. Based on her past experience, Heather recommended that one doctor rather than several doctors be in charge of the unit. She also advocated the use of ward government, watch programs and group therapy as a means to manage patient's behaviors. Heather felt that the care given to the patients in this institution was too fragmented and that CC was isolating and unfortunately over used because there was no unifying philosophy among the leaders.

Summary Statement

The nurses gave a great number of alternatives to CC which could be classified into the themes of providing a safer environment (locks, isolation rooms, moving the units), allowing for nursing judgement, increasing the quality of nursing care and changing the philosophy of ward management.

Unit Supervisors

The Unit Supervisors were extremely supportive of CC and felt there were few acceptable alternatives. Sheila recognized that CC was congruent with a certain philosophy of mental health, as reflected in the following quote:

> I mean, locking a door--would that be a solution? I don't think so. If you have voluntary and involuntary patients mixed together, you can't lock a door all the time. And is that really what you want to do anyway, is to lock up the unit, so that you make it safer. It costs less. But it's really not what your philosophy of mental health is--and how to help people get well again. I mean, the whole idea of having psychiatric units is to provide, I think, more contact and more individual help and counselling and direction and the support and having a therapeutic milieu.

Jason, too, supported this philosophy and noted that the assignment of two CC nurses to one patient was better 99 percent of the time than using a locked room for the patient.

Kristen indirectly supported Sheila's and Jason's philosophy by suggesting that the best alternative to CC was good nursing care. The kind of nursing care that included good assessment of the effects of medications, proper assessment of the patient, development of a working relationship, use of contracting to really involve the patient and having

the same staff members work with the patient. If the nursing care was excellent then an alternative to CC would be less rather than more CC.

Summary Statement

The Unit Supervisors were very supportive of CC and therefore were hard pressed to offer alternatives. The use of CC was congruent with a certain philosophy of mental health. The only alternative offered was excellent nursing care which would result in less rather than more CC hours.

External Review

The original transcripts were given to a nurse who worked in the field of geriatrics. She was asked to read the transcripts and to identify the themes that emerged. The data in Appendix G were the result of her work.

The value of having an external review is to identify biases, strengths and weaknesses. It is also imperative that the external reviewer perceive similar themes to the researcher even with only a cursory review of the data. The findings of the external reviewer are concordant with that of the researcher and thereby diminish bias in the study. The greatest value for the researcher was the issue of reliability since qualitative research is so difficult to replicate. Knowing that the external reviewer (as non interviewer) could identify similar themes as the researcher suggests that the interviews were comprehensive and that the researcher need not do everything in a qualitative study.

CHAPTER V

WHAT IT MEANS

The research study was directed by four research questions:

1. What is the meaning of CC to patients and nurses?

2. What is the relationship between CC and therapeutic effectiveness of the nurse-patient relationship?

3. What are the expected and appropriate roles of the nurse and the patient during CC?

4. What are the nurses' and patients' perceptions of the purpose and value of CC?

It is impossible to claim that the research questions were fully answered since the context of the research process kept changing. However, specific administrative and nursing actions were identified that would enhance the CC experience: the central meaning, therapeutic role, purpose and value of CC is to maintain life. The question is not to what extent life will be maintained, or what the quality of life will be, but will this patient live or die. In the following quote, Jay describes the basic meaning,

> And then I got badly one night, and like I've had a lot of physical and mental problems, like past relationships, best friends hurting themselves. And I got to the point where I had sort of snapped, and I said, no more. I couldn't handle it, so I was going to jump off a bridge. Matter of fact, I started jumping until somebody grabbed me from behind, which was a police officer, and pulled me back. They brought me in here, and from the time I come, I was automatically on constant.
>
> I'd be sitting in a pine box if the person wasn't sitting there all night, like even when they had me downstairs, I was looking for something that I could either swallow and . . . do destructively that way, or anything at all, it's something

> that just doesn't go away, like it's a sickness, you're sick. Like, it's not like it comes and goes. Like people say, oh, it's like a flu. It's nothing like that. It's always there.
>
> I was totally shocked because there was times I was thinking of hanging myself, but I tried that before, and the rope broke, then it hurt too much . . . I don't like pain. Where like--when I first come in here, if I would've ever had my guns, I would probably have shot myself at the time. I know that I would not be here today.

He understood and believed that he would be in a coffin had the nurse not been with him when his only release from his pain would have been death.

Judging from the patients' positive feelings about CC, they found it to be therapeutic. In contrast, the nurses found it to be negative, which should in turn decrease the therapeutic effectiveness of the nurse-patient relationship. Since this did not happen, an explanation can be found in the work of Maslow (1962). Essentially he developed a hierarchy of needs, with physical needs preceding psycho-social needs. Since the patients were considered unsafe and needed care with sleep, food, hygiene and sensory management, it could be argued that this level of basic physical care formed the extent of their expectations in a nurse-patient relationship. One of the nurses clearly stated that psychotherapy and health teaching happened after the patient was off CC, which would mean that if the nurse valued interactive, expressive skills rather than physical care taking skills, he would dislike giving CC.

Although both the patients and the nurses quickly articulated the purpose and value of CC, that is providing structure, caring, spending time, keeping the patient safe, being therapeutic and so forth, the value of CC to the nurses and patients became most apparent when others did not value it. For example, when patients went from CC status to a weekend

pass the nurses became very angry. Or when a patient remained on CC for weeks, the nursing staff felt this was abuse of CC. CC is valued when it is used appropriately, the merits of it are assessed frequently and when the patient is improving while on CC. The findings also revealed that there were implicit beliefs as to the type of patient worthy of CC and how qualified the staff should be.

Relationship of Role Theory to Findings

Patient's Role

The conceptualization of the sick role is usually viewed in a temporal, linear fashion beginning with symptoms, assumption of the sick role, medical care, assuming a dependent status and ending with recovery (Parsons, 1951). The experience of CC is a version of an intense, compressed sick role beginning and ending with a doctor's order. After the patient commences CC, she must learn about role expectations, sanctions, and how to manage role conflicts.

The patients in this study had numerous role expectations of the nurses as evidenced by their descriptions of nursing actions that were helpful: providing structure, showing respect, teaching skills and caring. They also wanted the same gender nurse to care for them and not to be interrogated by relief nurses. While they expected the nurses to be clinically competent, they showed more interest in the personality of the nurses. Tagliacozzo and Mauksch (1979) support this finding in the following passage, "most patients feel quite helpless in evaluating the knowledge, skill and competence of nurses and physicians. This maybe one reason for their intense emphasis on personality" (p. 182). They explain

the reasons for this position in terms of the role behaviors of helplessness, restraint and lack of control. Patients perceive that they will receive negative sanctions if they question the competence of professionals. Their own goal of getting well means being cooperative with the nursing staff regardless of the quality of care; and, a belief that nursing care is governed by the severity of the illness, means there is always someone else who is more deserving of nursing care.

A few patients did not conform to this passive role by punishing a nurse, testing the rules, acting out and openly criticizing a nurse's behavior of withdrawal. As well, a few patients were highly critical of their doctor. This was quite unusual since "the physician's authority ranks supreme in the eyes of most patients" (Tagliacozzo & Mauksch, 1979, p. 173). The source of this role conflict is part of the patient's expectation that staff will be helpful in a way that is meaningful to them.

The value of researching the CC patient's role goes beyond the mere description of role expectations, sanctions and so forth. What is most significant is the patient's ability to teach nurses. The identification and description of the role is the first step and the second step involves learning about what patients want and need, understanding why they act as they do and changing nursing behavior based on the findings. Just as teachers need to learn about their students before they actually begin teaching, nurses need to engage in the same process with their patients. Roger's (1951) theory supports this claim by asserting that education begins by accepting the individual's own view of the world rather than how it appears to others. The patients in this study have given their own

view of the world and have been very explicit in identifying the exact behaviors of others they found helpful, providing indepth descriptions, recommending changes and sharing their feelings. Their realities were regarded as their truth and what they teach is up to the nurse to learn.

Nurse's Role

Like the patients, the nurses too had role expectations, obligations and conflicts. They were expected to care for CC patients regardless of the shift, their own personal preferences and whether or not they had just returned after days off. Their role was to provide safe, competent care to any CC patient. Conflicts arose though when they found it difficult to stay awake at night, other staff did not value CC, patients were aggressive, violent, manic or sleeping for long periods, patients had to be accompanied to the bathroom, and they had to stay with the CC patient even though they wanted to be with their other primary patients. Most nurses believed that the working environment was unsafe and this contributed to their role stress. The nurses also recounted numerous examples of role strain such as not being involved in a decision to take a patient off CC. Common outcomes of role strain identified by the nurses included worrying, feelings of frustration, insecurity and fatigue (Ward, 1986). Role captivity, meaning doing one thing while desiring to do another (Biddle, 1979), was frequently expressed when nurses had to do CC but felt no need for it, or when they had to manage a violent patient and did not want to.

Asking the nurses to identify and describe their role regarding CC was valuable for educative and administrative purposes. The nurses cited numerous interventions helpful in building a therapeutic relationship,

preparing for CC and so forth, which when shared with a novice nurse, can be used to teach him how to be more effective with CC patients. As patients can teach nurses, so can expert nurses teach novices about CC. Administratively, the nurses identified a number of problems with CC practice and policies which will be addressed in the next section.

Implications and Recommendations

The specific implications that arose from the results and corresponding recommendations will again be discussed in conjunction with the broad areas of nursing, administration, feelings, others, environment and alternatives. This will be followed by an examination of the current findings in relation to previous research findings and then suggestions for future research. The chapter will conclude with the researcher's perspective on doing clinical research using qualitative methods and limitations of the current study.

Nursing

Implications and Recommendations Generated From Results

1. Patients resented "unknown and intrusive" relief CC staff, which in turn diminished the therapeutic effectiveness of the nurse-patient relationship.

   Recommendations

   a) If possible, have regular staff do relief CC on patient;

   b) Relief staff need to understand that therapy is the privilege of the full time CC nurse and their role is restricted to observation;

   c) Reading of the chart by the relief staff in front of the patient should be restricted to the gathering of essential information.

2. The transition from CC to close observation for the patient is poorly managed. It is often accompanied by feelings of surprise or ambivalence for the nurse and the patient.

Recommendations

a) Patients need to be told about the nature of close observation while they are still on CC;

b) Some patients would prefer another level of observation between CC and close. This could be initiated by the nursing staff with certain patients;

c) If a patient is to come off CC, it would be best to do this early in the day so staff would have time to assess the patient's reactions to close observation;

d) One nurse suggested that patients be weaned or trialed off CC. If using this approach, the patients would be told that close was a trial and that if necessary CC would be readily available again to them;

e) Patients require a lot of reassurance about coming off CC. They need to be told that they might feel awkward, scared or confused.

3. The nurse who admits the CC patient forms a special bond with him.

Recommendation

a) If there is a choice as to which nurse is assigned to CC, the best nurse would be the one who admitted the patient.

4. The personality of the nurse was very significant to the patient. Even the way he dressed, spoke, walked and felt made an impact on the patient.

Recommendation

a) Match the patient and nurse based on criteria such as extroversion, introversion and personal preferences of the nurse.

5. A number of patients preferred nurses of the same gender and if they did not have a same gender nurse their anxiety would escalate.

   Recommendation

   a) Whenever possible match the genders of patients and nurses.

6. Patients appreciated nurses who self disclosed to them. The self disclosure helped the patient focus on something aside from their illness.

   Recommendation

   a) Nurses need to make more of an effort to initiate conversations revealing their interests and participation in events removed from the hospital setting.

7. Patients were able to identify specific nursing actions that they found particularly helpful. This meant too that the patients were very aware of the nurse's behavior even though at the time the patients were extremely ill.

   Recommendations

   a) A list of these nursing actions need to be circulated to the nurses;

   b) Nurses need to promote the patient's mental health even when he presents with severe mental illness.

Administration

Implications and Recommendations Generated From Results

1. The patients were aware of the criteria for the policies regulating CC. They were more concerned about how they came off CC than how they were placed on CC.

   Recommendation

   a) Patients need to be involved in the decision to take them off CC.

2. Off service casual staff appear to create a lot of difficulties for regular staff due to their lack of skill and knowledge and occasionally poor attitude. Some of them

require excessive teaching and support and therefore burden the unit with their presence.

Recommendations

a) Off service casual staff should be assigned to patients that appear to require minimal interventions;

b) The medical-psychiatric nursing casual pool should be further developed to ensure that adequate coverage can be supplied using this group;

c) A one day workshop should be offered to all casual staff on management of the disruptive, aggressive patient;

d) A simple orientation pamphlet should be developed for casual staff that highlights essential information: effects of medication, setting limits, role of safety, etc.;

e) Regular staff need to be cautious when denigrating casual or relief staff particularly since casual staff from the psychiatric-medical float pool are valued for their knowledge and skills.

3. The night shift is fraught with multiple problems and has the potential for being the source of legal action.

Recommendations

a) Patients need to be assessed as to the advisability of being on CC at night;

b) Most night nurses are very supportive of CC nurses by giving them extra breaks, checking on them, etc., but a few nurses neglect the CC nurse. Therefore, ways of supporting the nurses doing CC at night need to be discussed at the weekly staff meetings. It should be mandatory that CC nurses and patients be checked every hour just as the other patients are;

c) The Unit Managers should consider the possibility of allowing the CC nurses to use radios and audio cassette players with head phones to help the CC nurse stay alert;

d) Nurses should have discretion as to whether the patient needs to be on constant or semiconstant at night. A semiconstant status might mean

checking on the patient every five minutes or staying continuously with her but having the privilege of leaving for a short walk;

e) Currently if the CC patient wants to leave the unit at night to go to the smoking room, most nurses will let her but the same privilege is not afforded to her during the day. The nurse should be able to assess whether or not it would be safe for the patient to leave the unit to go to the smoking room regardless of the shift. If a casual nurse is caring for the patient and he feels he does not know this patient well enough to leave the unit with her, he can simply tell her or ask one of the regular staff to accompany them;

f) It may be advantageous for nurses to wear head lamps that would allow them to read but would maintain a dark environment for the patient.

4. Having a patient go from CC to a weekend pass undermines the nurses and decreases their morale.

Recommendation

a) This practise should be stopped.

5. The use of security guards was viewed negatively. The implications in using them were that nurses could not manage the patient and that the patient just required a "strong arm".

Recommendations

a) Rather than assigning a security guard, assign two nurses;

b) If a security guard is assigned, do so with a nurse;

c) When assigning a security guard request that the same one return to the unit as frequently as possible, since they require a great deal of teaching and support;

d) Ask security guards to wear street clothing to diminish an image of intimidation;

e) Administrative personnel should offer nursing staff programs on aggression control techniques;

f) Staff need to consider the value of setting up an assault support program.

6. Confusion and inconsistencies about policies regarding charting, pouring of medications and being in the bathroom with the patient created feelings of anger and anxiety.

Recommendations

a) The policies need to be written and circulated among the nursing staff;

b) The policy referring to the supervision of the CC patient in the bathroom is interpreted differently among nurses. This policy should be rewritten to reflect actual practice;

c) If a nurse must be in the bathroom with a patient they should be the same gender. This might mean the CC nurse would need to get a relief nurse when the patient uses the bathroom.

7. Nurses do occasionally initiate CC and regard their CC order as valid. The question arises: why is not all CC ordered by the nurse since they care for the patient on a 24 hour basis?

Recommendations

a) On a trial basis designate one nursing unit where the nurses will order and also discontinue all CC for a period of at least six months;

b) Prepare the nurses for ordering CC through inservices, decision-making scenarios and setting up a peer consultation system.

8. The practise of having patients on long term CC (over two weeks) was viewed as antitherapeutic.

Recommendation

a) The Unit Supervisors could initiate a review process whereby all patients on CC for 14, then 28 days, etc. would be assessed. After the patient has been on CC for two weeks, a special case conference involving the psychiatrist, primary nurse and Unit Supervisor should be held. Since each CC patient is reviewed on a daily basis this assessment would be different in its focus and essentially ask: "What are the therapeutic

advantages of having patient X on CC for this period of time?"

9. Doctors order the initiation and discontinuation of CC. Nurses do not always agree with their order but have to give or stop CC based on someone else's assessments. Some doctors involve nurses and patients in their decision-making process and these doctors are valued and respected for these behaviors.

Recommendations

a) On a trial basis designate one nursing unit where the nurses will order and also discontinue all CC for a period of at least six months;

b) When nurses disagree with certain doctor's assessments they carry out the order but do so grudgingly; others defer to the doctor without questioning his judgement but do question their own judgement. Currently the nurses do not feel supported by the Unit Supervisor if they disagree with a doctor's assessment. The Unit Supervisors need to develop more of an advocacy role for their staff members and at the very least channel the negative emotions of a frustrated CC nurse rather than letting those feelings be absorbed by the patient.

10. Lack of continuity of care is a problem for the patient. A stream of different nurses irritates and fatigues the patient. For a patient to have had 100 different nurses indicates that the welfare of the patient was not considered, only the needs of the institution to provide coverage for care.

Recommendations

a) The institution's administrative personnel have not recognized the problem of lack of continuity and have made no effort to provide the patient with the same nurse for even two shifts in a row. When booking casual staff they should be offered the opportunity to stay with a CC patient throughout the CC tenure or for as many shifts as the CC nurse would like to work;

b) One nurse suggested that there be a "CC hit squad". There would be a group of casual nurses who would specialize in giving CC;

c) When relieving a CC patient, the relief nurse if at all possible, should be the primary nurse. This would allow the primary nurse to assess the patients' progress and give him data with which to update the nursing care plan;

d) Since regular staff have a norm against doing CC, and since patient-nurse assignments are done before the nurse comes to work, it means that often regular nurses who may wish to do CC for two days in a row will not be assigned CC. In cases such as this, regular staff need to make a special written request to be assigned CC rather than leaving the decision to someone else;

e) Lack of continuity of care is related to the multiple roles and obligations of regular staff members. They must care for a number of primary patients, take charge of the unit, supervise students, etc. They also do not know how long the patient will be on CC. Any continuity of care with CC patients is likely not to happen unless it is carefully panned for. One way of increasing continuity while maintaining contact with other primary patients would be for the primary nurse do to four hour shifts with the patient for two days in a row, versus one eight hour shift. They could also initiate a mini conference time with the CC nurse to gain or give nursing directives. The CC nurse would be relieved for this in the same way he obtains relief for charting;

f) It may be helpful to post the number of patients on CC per week and the number and names of different nurses assigned to the patient. This would assist nursing staff when doing the patient assignments in determining the best nurse for CC. It would also provide feedback to administrative personnel as to the frequency of CC;

g) An ideal solution to provide continuity would be that each nursing unit would have its' own nursing float pool;

h) To assist in maintaining continuity the nursing care plan needs to be on the patient's chart so it can be updated every shift;

i) Multiple assessments of the patient by the different disciplines or even different nurses needs to be reduced. One strategy would be for the student interns to take on a primary patient

assignment; another strategy would be assignment of the complete history taking to one discipline.

Feelings

Implications and Recommendations Generated From Results

1. The nurse does use himself as a therapeutic tool. His feelings are a therapeutic force and acutely felt by the patient.

   Recommendation

   a) Given this knowledge the nurse needs to be aware of and monitor his feelings. If his feelings are negative because of the patient or another circumstance, the nurse should ask for a change of patient assignment.

2. One nurse evoked strong negative feelings in patients and in turn the patients were set back in their recovery. It is not known whether the primary nurse knew about this particular nurse. However if the patient is being properly assessed the primary nurse should be able to detect the effects of poor nursing care.

   Recommendation

   a) Nurses who give poor nursing care need to be confronted by the primary nurse. If the confrontation does not resolve the problem then both nurses should seek out the Unit Supervisor.

3. Most of the regular nurses view CC as a negative experience. Since this generates negative feelings for them and their patients the question needs to be asked: "What can be done to make CC a more positive experience for the nurses?"

   Recommendations

   a) Allow the CC nurse to indicate a preference for certain types of patients;

   b) Ensure there is a consultation between the doctor and CC nurse before the patient is taken off CC;

   c) Nurses who give CC need extra support. This can be accomplished by verbally acknowledging what they have done, checking frequently on them, assigning the same nurse for meal and charting relief so the CC nurse feels that someone is

working with him and not just relieving him, placing aggressive patients in private rooms close to the desk so the nurse knows that help is steps away, and on breaks brief the CC nurse about what has happened on the unit so he does not feel isolated;

d) The nurses do not want to be assigned CC on their first shift back after days off. They need the first day to re-establish contact with their primary patients.

4. The most common feeling that was used as a monitor for the patients' progress was trust.

Recommendations

a) A nursing care model could be developed outlining the different degrees of trust. This could be used as a measure of the therapeutic effectiveness of CC and as evidence as to when a patient should come off CC.

Others

Implications and Recommendations Generated From Results

1. The role and needs of family members have not been fully recognized. The concept of "family as patient" was addressed by only two nurses.

Recommendation

a) The involvement of the CC nurse with family members should be encouraged. They could be taught how to assess families with regard to function, teaching needs and type of support needed.

2. Currently a doctor orders whether or not a nurse should stay when a patient has a visitor. This creates problems because the doctor is not there to assess the visitor and so the nurse almost always stays - particularly for patients who are on CC for less than a week.

Recommendations

a) Nurses rather than doctors should order whether or not a patient can be alone with certain visitors;

b) If a patient is alone with a visitor, the visitor is then doing CC. The regular staff need to address this issue because if they support this concept then visitors who do CC need to be briefed, support and supervised.

3. The quality of the relationship with the doctor was important to the CC patient. When she did not give the patient what the patient wanted such as increased involvement in decision-making, the patient became more irritable. This feeling, in turn, had to be managed by the CC nurse.

Recommendations

a) Nurses need to address ownership issues with the patients. If a problem lies between the doctor and the patient and not the nurse and the patient, the nurse should direct the patient back to the doctor, and vice versa;

b) CC nurses should be present at doctor-patient interviews;

c) Since Unit Supervisors felt positive about their relationships with doctors they could assist the nurses in developing more positive relationships.

4. The patients in the smoking room had a powerful impact on the CC patient.

Recommendations

a) The conversations in the smoking room need to be monitored on a periodic basis. Nurses should be alert to problems of dependency, rise of an anticulture and just the giving of poor advice among patients;

b) The ideal would be to have a smoke free meeting room where patients could congregate thereby experiencing the psychological benefits of the smoking room without the harmful biological effects of smoke.

5. When the nurse was disciplined in front of the patient, the patient too felt disciplined.

Recommendations

a) If a nurse needs to be disciplined it should not be done in front of the patient;

b) All interactions the nurse has with others while on CC may be potentiated disproportionately by the patient due to the CC experience.

Environment

Implications and Recommendations Generated From Results

1. The nurses had a number of observations about the environment and overall found it unsafe and in need of many improvements.

Recommendations

a) The nurses should document their concerns about the physical aspects of the environment and organize them in the form of a brief to be submitted to administration;

b) A number of nurses recommended that the door adjacent to the bridge be locked at night;

c) The nurses believed that a CC patient should not be automatically given a private room but be assessed as to degree of illness, the type of personality of both the CC and non CC patient in the room, the need for aloneness of either patient, etc. It was felt that some CC patients fared better with a room mate;

d) The reception area needs to be renovated to reflect a warmer, friendlier atmosphere;

e) A receptionist should be hired for at least six months, who would sit in the pod area behind a small desk. His role would be to greet visitors, direct patients and to observe whether patients on close left the unit. The receptionist could be funded on a government grant.

2. Since the CC patient is restricted to the unit, the nurse needs to be sensitive to the patient's needs for privacy and control of her territory.

Recommendations

a) The nurse needs to ask the patient about her feelings related to privacy and space;

b) When a patient is dressing, skin inspections should be done quickly;

c) The patient could be assisted in demarking their territory by moving chairs to certain angles putting up pictures, etc.

Alternatives

Implications and Recommendations Generated From Results

1. The alternatives to CC included a different system of observation, alterations in the environment and good nursing care.

Recommendations

a) The nurses could trial a different system of CC such as checking the patient every five minutes, reducing the nurse-patient ratio to 1:2 for certain patients or using a flexible CC approach whereby if the patient was awake a nurse would be there but if asleep or if visitors were present the nurse would have the option of leaving for a short time period. Regardless of the system employed, data would need to be kept on frequencies of CC, safety issues and concerns of the patients and nurses;

b) Locked units and seclusion rooms are not recommended given the research that has demonstrated patients feel bitter towards hospitalization if treated by being secluded;

c) Provision of good nursing is in part ensured by the hospital's quality assurance programs and desire to be an accredited facility. It is also the mandate of every Unit Supervisor to monitor the nursing care provided by the nursing staff. As a check to the nursing care provided a follow-up research study could be done on discharged patients assessing them for their satisfaction of the hospitalization experience.

Future Research

The current study was descriptive and exploratory and as such has helped identify aspects of CC that could be quantified. For example the following studies would be helpful in measuring and objectifying the CC experience:

Research Questions and Measures

1. How could incongruities in role expectations for CC patients and nurses be reduced?

   Measure

   a) Administer revised form of Psychotherapy Expectancy Inventory to the patients and nurses.

2. How stressful is CC for the patients and nurses?

   Measures

   a) Take physiological measures such as blood pressure and galvanic skin responses;

   b) Administer State Anxiety Scales.

3. Is there a relationship between on unit suicides and frequency of CC hours?

   Measure

   a) Tabulate frequency on CC and suicides; correlate the two findings.

4. Is CC more effective when patient is in a private room versus a semi private room?

   Measure

   a) Tabulate frequency of CC and type of hospital room; correlate the two findings.

5. Is there a difference between patients who were on CC and those who were not in regard to their satisfaction with hospitalization?

Measure

a) Measure patient satisfaction at time of discharge one month and then six months afterwards.

6. Is there a relationship between the territorial needs of the CC patient and self-esteem?

Measures

a) Administer Modified Behavioral Assessment Tool;

b) Administer Altman's Orientation to the Concept of Privacy;

c) Administer Allekian's Territorial Intrusion Questionnaires.

7. Is there a difference between doctor versus nurse ordered CC?

Measures

a) Set up a unit where only nurses order CC. Measure frequencies of CC, safety issues and concerns of the patients and nurses;

b) Measure decision-making process of nurses. Ask them to explain how they would solve certain problems; administer decision-making tests; and, have them generate scenarios which demonstrate how they have solved problems in the past.

c) Ascertain what nurses perceive to be dangerous patient behaviours.

The research study also identified two separate areas that need to be considered using an exploratory, descriptive design; they are the culture in the smoking room and the meaning of trust. It would be fascinating to find out the therapeutic effect of being in the smoking room. One also wonders if patients began to smoke during hospitalization as a means to achieve group support. Trust was mentioned repeatedly by nurses and patients. The question for research purposes could be simply

stated, "what is it like to trust?" using phenomenology or "what is trust?" using grounded theory.

The current research project, in a sense, raises more questions than it answers. It is easy to see how a life long research program could be developed around a simple behavior such as CC.

Relationship of Current Findings to Previous Research Findings

Since so little research has been done on CC it is difficult to compare the findings. There are a few isolated previous findings that do however relate to the current research project. Goldberg (1987) surveyed 118 general hospitals and found there was no consistency among hospitals concerning policies for CC. He also found the initiation and discontinuation of CC created difficulties particularly if different disciplines were involved in making these decisions. In this study these issues too created difficulties for the staff and patients. The policy about CC needs to be re-examined to reflect current practise and the transition from CC to close needs to be changed to include the patient and nurse. Aidroos (1986) concluded that nurses did not follow doctor's orders for close observation and based their care on their own assessments. This finding was indirectly supported by the patients and nurses; CC means continuous attention but close means checking on the patient every five minutes (organic brain disordered patient) or every 30 minutes (medication controlled psychotic patient). Phillips et al. (1977) found that the main purpose of giving CC was to provide a safe environment and that 75 percent of the nursing staff were dissatisfied giving CC. This finding was supported in the current project with the caution that

responses were not tabulated to reflect percentages. However patients did appreciate CC more than the nurses who had to give it. Briggs (1974) found that patients viewed CC as negative and custodial in nature. This finding was definitely not supported and in fact the opposite attitude was the norm.

The research on territoriality showed that verbal content of an encounter was more intrusive than a physical encounter (Smith & Cantrell, 1988); and that patients preferred relatives then doctors, nurses and strangers in their territory (Geden & Begeman, 1981). The patients in the study did not comment about territorial concerns nor did they differentiate as to whom they preferred to have close to them. In fact the behavior of being on CC while having visitors was viewed positively by some and negatively by others. Privacy was an issue for the patients and was mentioned as a concern when they were in the bathroom, eating or dressing.

Brizer et al. (1987) found that staff underreact to aggression and consequently do not receive sufficient support for their feelings of victimization. Lanza (1984) did a follow-up study of 99 nurses who had been assaulted and found they were reluctant to discuss their feelings. These findings were not supported in the present study and in fact the opposite was true; the nurses quickly identified their negative feelings about assaultive patients and also were reassured that support was available to them. Podrasky and Sexton (1988) findings that nurses will take out their anger towards patients on a third party can not be substantiated in this project. Only one nurse mentioned that she shared her anger with her husband when she had been assaulted at work. Gallop

and Wynn (1987) found that certain psychiatric patients created feelings of anger and frustration in staff members. This observation was supported in the way some nurses resisted caring for patients that had the "wrong" diagnosis, were alcoholic, on CC for a long time period, or very aggressive. Gallop and Wynn also observed that nurses and doctors differed in their affective responses to patients - nurses were highly personal and doctors distanced themselves. This finding would explain why nurses and doctors do not concur when they individuallly assess how long patients should be on CC or when they should come off CC.

The alternatives to CC that have been researched include the use of seclusion rooms, locked units and mechanical restraints (Carpenter, Hannon, McCleery & Wanderling, 1988; Ransohoff, Zachary, Gaynor & Hargreaves, 1982; Soliday, 1985; Wysocki, 1984). The findings demonstrate that patients and staff have discrepant views on the advantages of restricting a patient; particularly that staff are unaware of a sustained negative impact this has on the patient. The patients in the current study did not volunteer that restricting them in any way was an alternative. The nurses did mention these alternatives but did not necessarily support using them. Only one nurse mentioned that an isolation room used on a short term basis was the best alternative for very aggressive patients.

The research on satisfaction of psychiatric patients with hospitalization revealed a few findings that were supported in this study. As stated, matching gender of the patient and the therapist was very important (Urguhart et al., 1986-1987); contact with other patients was valued (Piersma, 1986-1987); it is difficult for patients to maintain a

sense of dignity and normal privacy (Osofsky & Fry, 1985); and, it is important to match the patient and the therapist (Clarkin, Hurt & Crilly, 1987).

Examination of the relationship between previous and current research findings assists in identifying the value of using in depth interviews, demonstrating priorities in pursuing research projects and formulating future research questions.

The Last Word

This was meant to be a manageable, simple research project asking a few questions about an observable behavior and employing a standard qualitative research design, "so why then did it take the researcher almost two years to complete?" A second question that also needs to be asked concerning the use of time is, "was it worth it?" The questions do not have answers but they are ones that created the most problems for the researcher. In part the caution would be to think twice about doing clinical research and secondly, no one can correctly estimate the time required by qualitative methods.

Doing clinical research meant presenting the research proposal and asking for permission to do it from the nurses, administrative personnel, doctors and ethic committees; it was a process that took three months. Gaining the opportunity of interviewing the first patient took nine hours only to have her terminate the interview because she was tired. Interviews were set up and then cancelled, a doctor became incensed that a patient revealed information about active suicidal ideation to the researcher and berated the nursing staff for letting the researcher near

his patient, and a patient demanded of staff that the CC policy be changed immediately because the patient had been a participant in the study - these are examples of events that took time to discuss and resolve.

Qualitative research is also a culprit in consuming time by days, weeks and months. Valuing every word the participant speaks, noting the context and moving continuously between the inductive and deductive methods of analysis seem like simple endeavors but in reality the process never stops. The researcher has concluded that qualitative research is very elitist. Where else in society does a worker have the privilege of mulling over for weeks the value of a certain intervention? It is a method of research that tolerates no short cuts nor does it lend itself to quick statistical analysis. The researcher is locked into a process of enquiry that in some ways cannot be controlled.

As with all qualitative research this study too is limited by an inability to generalize the results. The patients, nurses and Unit Supervisors are from one institution and may be a unique sample when considering the entire population. Since the sampling protocol consisted of a nonrandomized, convenient, small sample, only participants with a special interest and ability to articulate their thoughts and feelings about CC may have contributed to a bias in the findings.

Another limitation that became obvious half way through the research process was that doctors should have been included in the interviews. The researcher was not prepared in anticipating how influential the actual administration (ordering it, staffing, stopping it) of CC was on the giving of CC. When permission was sought to include doctors, a committee member wisely directed the researcher back to the research questions and

pointed out that finding about the doctors' perspective was another project.

Another limitation is that this type of research is almost a curious blend between psychotherapy and interviewing. The foundations of therapy have to be established - empathy, respect and genuineness but the goal is to get the participant to talk about CC. When a participant talked about a topic not related to CC, the comment had to be listened to but not supported.

When two patients revealed the name of the nurses who had abused the CC relationship the researcher felt in a quandary - exposing the name of the nurse would mean the halt of the research project. When the researcher asked the Unit Supervisor about this nurse, it was with relief, that she was told this nurse had resigned. However, this event highlighted a problem about doing clinical research because the researcher may have been gathered data that would have had immediate ethical consequences. Other issues concerning the problems of doing clinical research involved one psychiatrist who resented his patient consenting to be interviewed, a patient demanding the CC policies to be changed because she had been a participant in the study, and a patient who fell asleep after twenty minutes into the interview because she was tired. Arranging times to interview participants proved to be difficult due to the dynamic nature of the hospital. Prearranged interviews had to be cancelled because of laboratory tests, visitors, or group sessions claiming the participant's time.

The research project generated a number of new insights, recommendations for improving the quality of care and new research

directions. The researcher appreciated the support of the nursing staff and administrative personnel. Their attitude was critical in ensuring the success of the project; for example, when the researcher got bogged down with minutiae a staff member would come by and relate a new question about CC, or offer a suggestion to enhance the CC experience. Their enthusiasm for the project sustained the researcher.

One scenario that kept on reoccurring in the researcher's mind was, "What would the ideal CC experience be like?" It might read like this.

> The patient is admitted and has not previously been admitted to a psychiatric hospital. He is very suicidal and has a concrete, realistic plan of how he will kill himself. The male regular staff nurse admits him and also spends an hour with this man's family assessing their reactions, knowledge and need for support. The nurse provides CC for this patient for the remainder of the shift and for the next three shifts after which the patient no longer requires CC. The male nurse prefers working with depressed patients. He finds this patient to be in great need of reassurance, direction and teaching - needs he knows he can meet competently and easily. The patient secretly sees the nurse as his role model and wishes he can be as balanced as his nurse. After the CC experience is over the patient feels renewed, and safe with his feelings and thoughts. He knows he can trust himself and others.

REFERENCE LIST

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APPENDIX A

GUIDING QUESTIONS - NURSE

Appendix

Guiding Questions - Nurse

1. Describe what it is like for you to provide CC to a patient.

   a) to be with him/her constantly: sleeping, eating, toileting.
   b) what aspects of the care do you like? dislike?

2. What is the purpose of providing CC?

3. From your viewpoint, how does the patient respond to CC?

4. When you are informed at the beginning of the shift that you will be giving CC, what is your usual reaction?

5. Recall patients to whom you gave cc.

   a) describe a positive experience.
   b) describe a negative experience.

6. What feelings do you have when giving CC?

7. Often relief staff give CC, what is your reaction to this?

8. When is CC appropriate?

9. How effective are you in giving CC?

10. Is it different providing CC on

    a) days, evenings or night shift
    b) week days, weekends

11. Do you believe there are more effective alternatives to CC? If so, what are they?

12. Are there any specific nursing actions that you have found to increase the effectiveness of CC?

APPENDIX B

GUIDING QUESTIONS - PATIENT

Appendix

Guiding Questions - Patient

1. You have been on CC this past week. What were the reasons for being assigned this type of care?

2. What was it like for you to have a nurse with you constantly?

   a) while eating
   b) sleeping
   c) toileting
   d) visiting with family and friends

3. How did the other patients react to you when they noticed you were receiving CC?

4. Think of one nurse that was particularly (a) helpful to you, (b) unhelpful.

   a) How did you feel being cared for by this nurse?
   b) What did she do in particular that was helpful? Unhelpful?

5. A decision was made this week to discontinue CC for you, do you agree with this decision?

6. Were you able to wear your own clothing while receiving CC? If not, what was that like for you?

7. If you had to have CC again, how would you feel about that?

8. What changes would you recommend to make CC a better experience?

9. Did you feel you had input into your plan of care?

APPENDIX C

INFORMED CONSENT FORM (PATIENT)

Appendix

Informed Consent Form (Patient)

As a patient admitted to the adult psychiatric unit at this agency, you have had the experience of being cared for constantly by nursing staff. I, the researcher, Olive Yonge, would like to know you how felt receiving this kind of care and what could be done to improve the nursing care given to you.

I have talked to your doctor to obtain his permission.

It will take approximately two hours of your time in two or three sessions, to be interviewed. Your identity will only be disclosed to your doctor, unit supervisor, and primary nurse.

I will need to audiotape our interviews so that I may study your comments. Your name will not be used on the audiotape and you will be assigned a code number to protect your privacy. At the end of the project the data collected will be destroyed. However a copy of the findings will be given to you if you so wish.

You may withdraw from the study, or refuse to answer any questions, without penalty.

You will not benefit directly from the study.

You are free to ask any questions you have regarding this study.

Investigator	Date	Signature	Date
		Witness	Date

If you would like to review the report (findings) from this research project, please print your address on the space provided below.

_____

APPENDIX D

INFORMED CONSENT FORM (NURSE)

Appendix

University of Alberta
Informed Consent Form (Nurse)

Project Title: Nurses and Patients' Perceptions of Constant Care in an Acute Care Psychiatric Facility: A Descriptive Qualitative Study

Investigator: Olive Yonge
University of Alberta
Ph. 432-6258

Purpose of Study

The purpose of this study is to investigate the meaning of CC to nurses and patients in a psychiatric department of an active treatment hospital.

Procedure

Personal interviews based on a semi-structured questionnaire format will be used. The informant will be interviewed for at least two one hour sessions. All interviews will be tape-recorded and transcribed. Audiotapes and transcriptions will be kept in a locked drawer in Clinical Sciences 2-145.

Consent

I hereby consent to be interviewed concerning my thoughts and feelings about CC.

I understand that my identity will not be disclosed at any time and at the end of the project the information will be destroyed.

I further understand that I may withdraw from the study, or refuse to answer any questions, without penalty.

I do not expect to benefit directly from the study.

I am free to ask questions I have regarding this study.

_____	_____	_____	_____
Investigator	Date	Signature	Date
		_____	_____
		Witness	Date

If you would like to review the report resulting from this project please print your address on the space provided below.

_____

APPENDIX E

DAILY NURSING ASSIGNMENT RECORD

Daily Nursing Assignment Record

Date: 10 2 | 10 3 | 8 9 (day / month / year) Subunit

Days - Scheduled Staff

		Educational Activities, Reminders
John Johnstone	Victoria Sbury	Doctor's Rounds
Mary Smith	Angus Hengisjan	Nursing Conference "11"
Ruth Dyakicky	Terry Jessitson	Staff Mtg. 14 50 HRS
Judy Hanley	Eve Everson	

Evenings - Scheduled Staff

Issy Lobbel	Susan Jonson
Jay Sheldum	Peter Derry
Marian Brown	
Margery Pelleville	

Nights - Scheduled Staff

William Clark
Rosa Holland
Sam Berry
Terry Russo

Days — Nursing Unit Supervisor: Jessica Hawke — Nurse in Charge: RN Mary Smith

Early Evening — RN Marian Brown — Late Evening — RN Peter Derry — Nights — RN William Clark

Staff/CL	Nurse	Break	Rm	Patient	Type	A.D.T. Updates	Early Evening Nurse	Break	Late Evening Nurse	Break	Nights Nurse	Break
	Eva Everson	½	0-1	Grafo	3		Jay Sheldum:		2nd Admission		Clark	
			0-2	Hadin	2		Relieves CC#1				Holland	
	Relieve C/C #1		1-1	McCue	2						Clark	
	John Jenkins	½	3-4	Gray	1	Transf to H10	Marian Brown		1st Admission		Clark	
	Relieve C/C #2		8-1	Stoltze	3		Relieve CC#2					
				Winter	2							
	Mary Smith	½	2-0	Koppel	3		Issy Lobbel				Holland	
			2-1	Stone	2		Relieve CC#3					
	Relieve C/C #3		3-2	Young	1							
	Ruth Dyakicky	½	3-3	Tobia	1	D/C	Margery Pelleville		3rd Admission		Clark	
			1-2	Morris	1							
			8-2	Kennedy	3							
	Judy Hanley	½	6-1	Kyle	3	Pass at 1200 hours	Susan Jonson				Holland	
			6-2	Chilton	2							
			7-1	Whyte	1							
#1	Victoria Sbury	½	C/C	Vamberkel	4		Peter Derry C/C		Dowille C/C		Berry C/C	
#2	Angus Hengisjan	½	RC/C	Goudreau	4		Bowels C/C				Russo C/C	
#3	Terry Jessitson	½	C/C	Moraes	4		Andrews		Jenkins C/C →			

APPENDIX F

RESEARCH SHEETS

Unit ______________________ Date ________________ Year _________

Patient ____

Shifts 7 - 3 __________________ Shifts 7 - 3 __________________

3 - 11 __________________ 3 - 11 __________________

11 - 7 __________________ 11 - 7 __________________

Other __________________ Other __________________

____

Shifts 7 - 3 __________________ Shifts 7 - 3 __________________

3 - 11 __________________ 3 - 11 __________________

11 - 7 __________________ 11 - 7 __________________

Other __________________ Other __________________

____

Shifts 7 - 3 __________________ Shifts 7 - 3 __________________

3 - 11 __________________ 3 - 11 __________________

11 - 7 __________________ 11 - 7 __________________

Other __________________ Other __________________

____

Shifts 7 - 3 __________________ Shifts 7 - 3 __________________

3 - 11 __________________ 3 - 11 __________________

11 - 7 __________________ 11 - 7 __________________

Other __________________ Other __________________

____

****

Total Shifts of CC ____

Number of Different Nurses ______________________________________

APPENDIX G

EXTERNAL REVIEW

Appendix

Patients

Sally

1. Patient knows that CC is expensive;
2. Presence of nurse did not alter how much food she ate;
3. Relief nurses aren't "good" because they don't know you, and you can't talk to them, you have to know someone as a nurse;
4. If relief nurses are going to be around for 15 minutes they don't have a need to read the whole chart. The privacy of the patient is important;
5. Nurses need to listen to patients;
6. Patient feels she needs to entertain CC nurse;
7. When a nurse "cares" she needs to focus on patient (not phone her kids);
8. Patient would like to have the primary nurse, the nurse should not always be in charge;
9. The nurse needs to have a socially appropriate relationship with the patient;
10. It's hard to "start from square one" which each nurse;
11. There is no consistency among the nurses about watching the patient in the bathroom;
12. The nurse shouldn't stare at the patient while eating, (it's not polite). She should talk or read a book;
13. Hospital clothing are safer than street clothing;
14. At night the lights shouldn't be on in the patient's room;
15. While on constant, you shower rather than bath. You can hide behind the curtain and have a little privacy;
16. The nurse should focus on the patient and not walk off and leave her;
17. The nurse should repeat herself over and over and tell each patient her plan of care, even though it is hard;

18. Male nurses make her feel uncomfortable particularly when she showers. Also going to the bathroom is embarrassing.

Colleen

1. It is hard to have different nurses all the time;

2. Male nurses make you feel uncomfortable, even unsafe;

3. The other patients exclude you when you are on constant - they expect the constant will be your social conversation person;

4. Good nurses DO something, they encourage you to think positively. They play cards with you and the structure this provides is very good. They also go for walks with you;

5. Poor nurses do not focus on you. They read the paper;

6. Polite nurses knock on your door and introduce themselves to you;

7. Nice conversations make you feel good;

8. It was good when nurses reminded the patient about what was said when the doctor visited. It makes the patient concentrate more on the visits;

9. Good nurses focus on you. They review the doctor's visits, find good things to talk about and even focus on you when they leave the unit - one nurse brought in her old clothing for the patient.

Marcia

1. When the patient went to the bathroom the nurse thought the patient might hurt herself and the patient did not like that feeling;

2. The patient was nervous eating because she was watched;

3. One bad nurse stole the patient's pen and took her blush;

4. Good nurses are like mothers, they take care of patients, but when the patient did bad things she felt guilty;

5. The patient felt like she was in a fog. The nurses told her what to do and that made her feel more in control;

6. The patient did not care for male nurses;

7. Felt threatened when the nurse said she did not have to take her pills because the doctor had ordered them for her;

8. Having a nurse stay with the patient in the room when she had visitors made her feel crazy.

Wendy

1. The bathroom is a bad place for the patient. The nurse is justified in having the bathroom door open;

2. The patient was irritated when the nurse stayed with her when she had visitors;

3. One male nurse threatened her the entire shift;

4. It is good if the nurse reads the chart and prepares herself for doing CC;

5. It is better to have one nurse for a long period;

6. Constant care is only good if you need it;

7. Nurses encouraged patient to make decisions;

8. Felt well cared for on constant. Like the way the nurses sat, made it more "normal". Also told the patient what was happening outside of the hospital - weather, date. Appreciated that they talked to her room mate;

9. Did not like being asked for explanations - she does not understand her own behavior, let alone explain it to anyone;

10. The patient found that not all CC is personal. Found it was better when it was personal and interest was shown in her;

11. The patient did not like having relief nurses pry and solving her problems. She preferred nurses she knew;

12. The patient said it was not good to be on CC too long because you forget how to be on your own.

Jay

1. The patient found it good to be on CC to avoid hurting himself, he felt secure but also irritated;

2. CC means the patient is task oriented and can not relax nor have freedom to smoke as much as he wants;

3. CC is "isolating" from other patients;

4. Being stared at made him feel paranoid;

5. The patient felt everyone asked the same questions over and over again. He thought it would be better to build a relationship before asking a bunch of questions;

6. The patient felt the nurses should be there for him and that he should not have to wait (to go smoke) or be told what to do;

7. The patient did not trust his doctors;

8. The patient understood that nurses have other things to do besides look after him;

9. The patient missed other patients while on constant and disliked staying inside;

10. He felt CC should have been discontinued for him after the alcohol cleared his system;

11. When nurses talked about "normal" things like horse back riding, he enjoyed himself;

12. CC made eating uncomfortable but dressing posed no problem.

Lucy

1. While on CC the patient felt invaded, not trusted, annoyed, up tight and in turn this made her feel less in control;

2. If the patient knew or liked the nurses it made her want to behave better;

3. The patient said it was O.K. to be on constant if you are going to hurt yourself but it was not O.K. if you can not get your own way or if you do not need it;

4. The patient understood that it was a comfort because she could not hurt herself. She did not like it but it was good for her;

5. The care in the bathroom was inconsistent. She felt the nurses should not be so strict, that they know if you are going to do something stupid;

6. It was embarrassing to shower with the door open wide. The nurses who knew and trusted her did not sit in the bathroom with her;